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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF NEW YORK

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: 99-CV-7392ROBERT A. FALISE; LOUIS KLEIN, (JBW)

JR.; FRANK MACCHIAROLA; and :CHRISTIAN E. MARKEY, JR.,

AS TRUSTEES, :

Plaintiffs, : United States Courthouse

-against- Brooklyn, New York

:THE AMERICAN TOBACCO COMPANY;

R. J. REYNOLDS TOBACCO COMPANY; :BROWN & WILLIAMSON TOBACCO

January 12, 2001

CORPORATION; : 9:00 a.m.PHILIP MORRIS INCORPORATED;

LIGGETT GROUP, INC.; and :LORILLARD TOBACCO COMPANY,

: Defendants.

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TRANSCRIPT OF JURY TRIAL BEFORE THE HONORABLE JACK B. WEINSTEIN

UNITED STATES DISTRICT JUDGE

APPEARANCES:

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Transcript produced by CAT.
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1 (Open court.)
2 THE COURT: Falise for trial.
3 MR. STENGEL: Good morning, your Honor.
4 THE COURT: Good morning. What can I do for you?
5 MR. STENGEL: Your Honor, I think there are some
6 document issues.
7 I apologize for not having been here at the end of
8 the day. I have both Mr. Austern from the Trust and Dr.
9 Harris available at this point in time, and would
10 anticipate -- we had anticipated, as your Honor knows, putting
11 on just Dr. Harris and doing not only rebuttal of the some of
12 the issues raised by Dr. Wecker, but putting in the Trust
13 numbers through Dr. Harris.
14 If the court feels it would be more appropriate for
15 the dollar amounts actually paid in toto to be put on by a

Trust witness, Mr. Austern is able to do that.
THE COURT: That is up to the defendants. How do you want to handle the numbers?
MR. BERNICK: We have a series of problems. Did the court receive our correspondence this morning?
THE COURT: I received your correspondence with respect to the model, plaintiffs' testimony on the model.
MR. BERNICK: There was also in the same correspondence -- it dealt with the Trust's damage claim.
THE COURT: I didn't notice that, I'm sorry.

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MR. BERNICK: I will just recap for the court. Yesterday evening, your Honor, around 7:00 o'clock, we received a new set of numbers. Then even later on in the evening we got a further set of numbers later on that related to the consumer protection statute claim in particular.
Both these sets of numbers share a couple or three fundamental defects that make it very difficult to proceed. Number one, is that neither one of them, as far as we can determine, are in accordance with your Honor's order that the only claims that would be recoverable are those that have been either paid or approved for payment as of December 31 of the year 2000.
Unless something else has changed, I believe that both of these calculations or both of these claims would include claims that are actually approved for payment after the end of 2002.
THE COURT: After 2002?
MR. BERNICK: After 2002. The claim would come in, the Trust would expect that it would be paid, but it wouldn't actually be paid --
THE COURT: That is not my ruling.
MR. BERNICK: That is my understanding. Maybe something has changed, but all that we received were the numbers.
At this point we don't know whether the numbers are

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in accordance with your Honor's order.
THE COURT: Let's find out. That is easy enough. Let's find out what the numbers are.
MR. STENGEL: The easy way to do this, I suppose, is to put these on the Elmo. We have similar presentations for each of the three causes of action and, as Mr. Bernick mentioned, because of yesterday morning's ruling on the Consumer Protection Act, that has been the last to come through.
What we have done on each is present this in three pieces. The first calculation is the -- I have extra copies if it will be easier --
THE COURT: No, I can use the Elmo.
MR. STENGEL: The first calculation or presentation is settled claims as of 12/31/2000, literally claims that were resolved through the Trust, which I believe is in full compliance with the court's order.
We have broken down the presentation because we think, when we moved to try and capture claims through 2002, it does create what is an anomaly because we have a substantial quantity of claims that were in the possession of the Trust as of the end of 2000, which we know from the Trust normal operations will be resolved -- if you recall, Professor Harris presented a transition matrix, I believe it's Harris 9

25 or 10, to explain how he took unresolved claims and turned
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1 them into resolved claims.
2 Finally, we have a set of calculations --
3 THE COURT: Excuse me. I want you to follow my
4 instructions. If your expert is doing it in a slightly
5 different way, it may require some kind of reconstruction by
6 the jury, but I want it presented my way, that is up to the
7 end of the year 2000, paid or approved for payment, without
8 any leakage into 2001.
9 MR. STENGEL: The claims as of the end of 2000, paid
10 or approved, would be the first set of numbers.
11 THE COURT: That is --
12 MR. STENGEL: Ninety-four million.
13 THE COURT: Eighty-four million?
14 MR. STENGEL: Ninety-four.
15 THE COURT: Sorry. 94 million. Okay.
16 MR. STENGEL: Yes.
17 THE COURT: Is there any problem with that, that the
18 defendants have?
19 MR. BERNICK: No. If that's as being represented,
20 we believe that that would be in accordance with your Honor's
21 ruling.
22 THE COURT: They just put in the sheet without a
23 witness?
24 MR. BERNICK: As far as I can determine, that is not
25 a problem from our point of view.
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1 THE COURT: What about 2001, 2002?
2 MR. STENGEL: Well, your Honor, we have --
3 MR. BERNICK: Sorry, your Honor, the one that I was
4 speaking to is the 94. The second number is actually the end
5 of the year 2000 unresolved. It's not 2002, it's 2000
6 unresolved.
7 THE COURT: The first subhead is "settled claims as
8 of 12/31/2000." That comes in. It ends with 94 plus
9 million.
10 MR. BERNICK: Right.
11 THE COURT: The second group, "unresolved claims as
12 of 12/31/2000," is out. That is to be redacted because it
13 doesn't bear on what I asked for.
14 Right?
15 MR. STENGEL: Correct, your Honor.
16 THE COURT: Okay. Now we get into the 2001 through
17 2002. Let's raise that up on the machine, please.
18 I'm not sure, is this what you expect to have paid or
19 approved at the end of 2002?
20 MR. STENGEL: This is -- we get into projections
21 here, your Honor, what the 2001 through 2002 is, taking
22 Professor Florence's estimates of the claims that will be
23 filed by year end 2002.
24 THE COURT: That is not the figure I asked for. It
25 had to be reduced by the ratio of claims approved and paid to
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1 claims made because you don't pay all your claims.
2 What is the ratio? Bring the witness up.
3 MR. BERNICK: These are exactly the same questions I
4 asked about twenty-four hours ago.
5 THE COURT: All right. We'll get you your answer, I
6 hope.

THE WITNESS: Could I use this chart.
THE COURT: Give your name for the record.
THE WITNESS: David Austern.
THE COURT: You are still under oath, Mr. Austern.
D A V I D A U S T E R N,
called as a witness, having been previously duly sworn, was examined and testified as follows:
THE WITNESS: Yes, your Honor.
MR. BERNICK: One detail, your Honor. If we go back up to the first one, just so that we can be clear --
THE COURT: Are you using an erasable chart? Is there a piece of paper on that?
THE WITNESS: No, there isn't.
THE COURT: I don't want erasable charts. I want paper.
MR. BERNICK: The first one includes -- this should be redacted as well. That is the total cost to the Trust that is not at issue.
They should just have the 10 percent that they are
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seeking. This is not a cost to the Trust. They haven't paid that money. If they want to say it's a scheduled value, they can say that.
THE COURT: Column 5 is out. Column 5 is to be redacted. Is that understood by the plaintiffs?
MR. STENGEL: Yes, your Honor.
THE COURT: All right. Put down there Austern 1.
THE WITNESS: Your Honor, if one assigns on a vertical axis the alleged categories that one can receive, it would be 1 through 7, and if one, on the horizontal axis, has the categories that are paid, which is, of course, also 1 through 7, and run through the 300 thousand, approximately, TDP claims that have in fact been paid, one can look at the alleged disease for those 300 thousand and chart it as against the paid, and what one ends up with, of course, is a horizontal axis because the 1's would be overwhelmingly paid as 1's and the 2's as 2, etcetera.
THE COURT: You'll have to use the ratios for each disease then.
THE WITNESS: If I can just mention, your Honor, we can supply a transition matrix. For most of the categories we know that a very large percentage of what comes in as an alleged 1 is paid as a 1, all the way down to 7.
I'm sure it will not surprise the court to hear that when you GET to category 7, because we rely on pathological
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evidence, the ratio exceeds 90 percent. There are not very many doubts about pleural disease, the ratio is very high.
Category 4 is not a very high ratio because of the other cancers being multifaceted.
In any event, we know the transition matrix and, in fact, we employ it, not so much for this purpose, but for the purposes of cash reserves, thus, if we have 60 thousand pending claims, we have a pretty good idea during the year what our cash needs would be, based on the alleged versus the paid.
That is how we ascertain it. I can tell your Honor that as of 12/31/2000, there were 26,863 claims that had in fact been categorized where there were checks outstanding but uncashed.
THE COURT: Those are okay. Any check you cut or

approved for payment is okay. They come in.
To get back to the question we have. As of the end of 2000 you have the figures, actual figures. As of the end of 2002, can you apply your ratios to lung cancer, disabling BID and BID?
THE WITNESS: Based on Dr. Florence's figures, we can.
MR. BERNICK: Can I ask a question, your Honor?
THE COURT: Sure.
MR. BERNICK: Haven't you already done it?
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THE WITNESS: I would have to check to see if we have a transition matrix for the 2001 and 2002 categories.
MR. BERNICK: That's not -- my question specifically is, has the Trust performed, even on a preliminary basis, exactly the determination that the court just asked? Have you done it or not?
THE WITNESS: I have not done it. I do not believe it has been done, but I can find out.
THE COURT: When are you going to do it? I'm allowing you to put in proof on those two years, but you have to have it set. We're at the end of the case.
MR. STENGEL: I understand that, your Honor. We have been, I think, trying to get this done with a fair number of other moving parts at the same time.
Just let me -- can we go back to current claims? As I understand where your Honor is at the moment, would it be acceptable --
MR. BERNICK: I'm sorry. Mr. Austern's answer is disconcerting to me. It is hard for me to believe that, given what he has said with such assurance and clarity, the Trust doesn't know what that number is paid.
That Mr. Austern doesn't know it is somewhat astonishing, because I put exactly the same question to Mr. Stengel twenty-four hours ago, and your Honor ruled, I don't know whether it was three days ago -- Dr. Harris is
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here, other people from the Trust are here. Yesterday afternoon, it was convenient that nobody was here to be able to answer these questions.
Is there somebody else that the court can ask in the courtroom who can give us the number?
THE COURT: Excuse me. Let me concentrate on lung cancer. You expect lung cancers -- what you call "defendants' misconduct at the end of 2002" -- to be what?
MR. BERNICK: Those are pilots.
MR. STENGEL: These are transition numbers.
THE COURT: What is that?
MR. STENGEL: They have been through this process.
MR. BERNICK: So --
THE COURT: How many claims for lung cancer do you expect to get in the year 2001, 2002?
MR. STENGEL: This is extracted from Dr. Florence's work. This is for 2001, 2002. The filings expected --
THE COURT: Okay, those are your filings?
MR. STENGEL: Right.
THE COURT: So your filings for 2001, 2002 forecast are 3,023, correct?
MR. STENGEL: If you include the Maritime Asbestos Litigation Clinic claims, it's 3,161.
THE COURT: Okay. How many of those do you expect

to approve for payment? What is your ratio as to lung cancer?
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THE WITNESS: I'm sorry, your Honor, I was listening to someone else.
THE COURT: That's all right.
MR. STENGEL: These have been transitioned to these numbers.
MR. BERNICK: They haven't been. They can't be. This is what is so strange, your Honor. If you take a look at what Mr. Stengel just put on the screen, he says with defendants' misconduct, which is the status quo, the number is 3466. That is future claims 2001 through 2002.
The number he just showed you is actually less. It says a total for 2001, 2002 as being 3023 and, including filings, 3161. They don't match.
THE COURT: Take your 3,161. What is the ratio of lung cancer claims that you approved?
MR. STENGEL: The transition matrix isn't presented here. He's asking what the transition is as to lung cancers.
THE WITNESS: I would have to pull the transition matrix. I can tell you that the percentage is very high, but I will have to get you the percentage.
THE COURT: What do you mean by "very high"?
THE WITNESS: I believe lung cancers are a plus 70 percent alleged versus --
THE COURT: That's a big number.
THE WITNESS: It is, your Honor.
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THE COURT: Seventy times 3000 is a lot less than 3000?
THE WITNESS: I understand that.
THE COURT: I have to have these numbers.
THE WITNESS: I will get you the numbers.
THE COURT: Get them. If necessary, have somebody on the stand who can be cross-examined and put them in that way, then we'll know. Okay?
MR. BERNICK: I don't have any problem with that, your Honor.
THE COURT: I don't want to do it solely on the basis of these type pages because I don't have enough security about their etiology.
Now, let me get to another point while you're all here before me. There has been ample evidence that lung cancer is caused by smoking.
Are the plaintiffs satisfied that they have put in enough evidence that disabling BID and BID are caused by smoking?
MR. STENGEL: Certainly that the conditions are exacerbated by smoking, particularly in the context of leading to more claims against the Trust.
THE COURT: You are satisfied you have?
MR. STENGEL: Yes, your Honor.
THE COURT: All right. Then we need the numbers on
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that, subject, of course, to motions at the end of the case.
MR. STENGEL: Your Honor, just for this morning's proceedings, Dr. Harris is available to talk about these numbers. He is the person who did the transition for the future claims.
As I understand your ruling, we need to redact the

column 5, the cost to the Trust, because the defendants object to that being included because it's the all in 100 percent number.

THE COURT: Well, I don't care if you have it in, as long as it's explained. It's not actually the cost, it's the liability of the Trust.

MR. BERNICK: The scheduled value.

THE COURT: Or scheduled value, but it's not the cost. Just change it.

MR. BERNICK: This does not deal with the -- if you want to flip up -- the consumer protection action.

THE COURT: The consumer protection action, again, that is a model problem not a problem of 2001, 2002.

MR. BERNICK: That's true. If they want to present these numbers, the numbers assume the problem with the model, as your Honor knows, at least that we have with the model, which is that it doesn't really tie to conduct.

THE COURT: That is their burden to prove. I'm not going to intervene.

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MR. BERNICK: As a practical matter, your Honor, I believe that if they wanted to, they could have the numbers that we need even before 10:00 o'clock.

I've got a witness to call to the stand who needs that number. We said that before. I need to know what that number is.

THE COURT: Get on the phone and get your people to work.

MR. STENGEL: Let me just -- Mr. Bernick and I have apparently miscommunicated on this before.

What you are looking for is settled claims plus claims where the checks have been cut, is that what you're looking for?

MR. BERNICK: I'm looking for the Trust to comply with the court's direction to present the damage claim in this case in accordance with the court's orders, that's what I want, so that my expert can say, here's what the damage claim is. Here's what it means.

It's just that simple. It seems to me the court has given the direction. It's just a question of doing something that ought to be extremely simple, which is adding to your first number whatever number represents the additional claims that will be approved, given your matrix, by the end of the year 2002. It's just that simple.

THE WITNESS: Your Honor, at the risk of

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complicating this matter, may I make just one observation before I retire to have someone do the numbers?

THE COURT: Sure.

THE WITNESS: If you look at lung cancer, which, as your Honor will recall, is category 5 and category 6, I will tell you that 5's and 6's that come in as lung cancers, 86.3 percent -- I just looked -- are paid as lung cancers, but I may I point out to the court that category 1 claims that come in as alleged category 1's are sometimes paid as category 6, because we did medicals, all the way 2, 3 and 4.

THE COURT: Excuse me. I don't care what happens. All I want is the information I've asked for. If you can't supply the information in some semi-credible form so that a trier can rely on it, then you haven't made your case.

MR. STENGEL: Your Honor, I think there is one

confusion which I just picked up from Mr. Bernick's comment. This may just believe our imprecision in labeling.

What are called "unresloved claims," those include -- these have all been transitioned, and those include all the claims as to which there are checks outstanding which have not been cashed. So "unresolved" is not filings, these are all matrix; this is the Trust expectation.

THE COURT: You can't have them both ways. You can't have them as claims approved up to December 31 2000 and also incoming claims as of 2001.

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MR. STENGEL: Your Honor, these two collections of claims are both claims which were physically at the Trust. The difference is the top group, what we call "settled," means a check was cut and it was cashed. That transaction is completely final with the plaintiff.

The "unresolved" are at the Trust, many of them have been categorized, checks cut, but they haven't been accepted yet, but all of them have been through the transition matrix that Mr. Austern describes.

THE COURT: Excuse me. Present it any way you want. You know what I think you need to make a case. The rest is up to you. I'm not going to make the case for you.

MR. BERNICK: The difference between these two categories is irrelevant. The question is as of the end of the year 2002 is going to be proof of payment.

I feel very uneasy, your Honor. You ask, well, do you accept the numbers? I'm really going on, in a sense, the representation of the Trust that that first category has in fact been paid.

I'm going on Mr. Austern's representations in court and counsel's representations in court to that effect. When we get to these other categories, the more I hear the more nervous I get about accepting that representation.

We're talking about millions and millions of dollars.

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THE COURT: Even as to that first category, apparently, from what Mr. Austern has said, some of that first category is shifted into the 2001 because you've cut the checks but they haven't been cashed.

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MR. BERNICK: That's what makes me then leery of exactly what's in that second category.
MR. STENGEL: That's just not correct, Your Honor. What's in the first category, checks have been cut and cashed. Settled means we are done with the plaintiff. Fully resolved.
THE COURT: Okay. Okay.
MR. STENGEL: If I introduced any confusion on the second category I am sorry. The first category is absolutely done.
THE COURT: Okay. All right. Present it in any way you wish.
MR. BERNICK: We then have the very substantial problem -- did Your Honor get a chance to even look at the letter?
THE COURT: I have looked at the letter.
MR. BERNICK: Yes. There have been more developments since last night when I sent that letter at 11:15 and I went back to my room to start to work on my witnesses for today. First we received at 1:00 o'clock in the morning a whole package of materials relating to Doctor Harris who is sitting here in court today. This package of materials is substantial. I don't have -- it's a substantial collection of additional materials. It includes some demonstratives that were used on cross-examination of Doctor Wecker which I
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understand. It includes a whole new series of computer programs, all of which apparently are designed to be presented this morning.
Moreover, we analyzed the computer disks to the extent that we could. We had people working around the clock last night to come to even the vaguest understanding of what's there.
Doctor Wecker is available to speak to the Court right now by telephone and explain to the Court the volume of new work that's been done, and that work is very substantial.
I would feel more comfortable in discussing this if Doctor Harris, who is sitting there, would leave the courtroom because I may have to examine him.
THE COURT: Doctor Harris, please leave.
MR. STENGEL: Excuse us, please.
(Doctor Harris leaves courtroom.)
MR. BERNICK: I know that Doctor Wecker can explain it more adequately than I can. But we have been through this process with Doctor Harris before. This happened -- this is exactly a replay of what happened with the Selikoff data this last summer where the data came in. He was busy working on it, round-the-clock. Showed up at his deposition bleary eyed. He spent literally thirty days working on a whole new report, never told anybody about it. Until -- until our experts had gone ahead and done what they had to do. He came
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out with report number six and Magistrate Judge Gold struck the whole thing.
Your Honor reversed that because the trial date slipped.
It looks like the same thing has been done. He's now got a whole new series of calculations relating to the quit

dates which are so critical. He's got at least four new calculations. He relies upon new data inputs, not the original Rabinovitz data inputs, new data inputs.

So we have a whole new show that they are trying to introduce at this late date. It is an outrage to the Court. It is an outrage to the parties. It is absolutely intolerable. I can't understand how counsel for the Trust can countenance the submission of this data. I have never observed anything that comes close to this kind of thing, to say nothing before a court of such high regard as Your Honor. It is absolutely amazing to me.

If you call Doctor Wecker, he can tell you in more detail. There is no way that it is humanly possible for us to deal with this data in the context of this trial much less to have this data in this submission come forth with any notion of fair process in this trial.

We would move the Court to strike the testimony of Doctor Harris in its entirety. We believe that this is a totally improper move. Doctor Harris should not be permitted

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to take the stand. He should not be permitted to utter a word in light of what he's done here. Again, if Your Honor wants more details, we have to make a formal proffer, we will. Doctor Wecker is available by phone and I have his telephone number for the Court if you wish to call.

THE COURT: Well, consult with your colleague on the plaintiffs' side. I am not going to allow this witness to introduce new data.

MR. STENGEL: Your Honor, just so the record is clear --

THE COURT: I mean, he can reanalyze the other data.

MR. STENGEL: That's exactly what -- Your Honor, just so the record is clear, what he is going to respond to, first Your Honor may recall that when I was crossing Doctor Wecker, he took the position that he had done several other CPS II comparisons other than the asbestos only. We hadn't seen those. They weren't in the materials we had received. Doctor Harris went back to the existing data to see what had been done. Over the lunch hour, as you recall at a break in cross, Doctor Wecker did a new CPS II comparison, made the difference we found disappear. We have looked at that, because Doctor Harris needs to respond. As Your Honor knows, some very substantial allegations essentially of scientific misconduct were made through Doctor Wecker's testimony.

As to the selection of medical to medical data or POC

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to POC data, Doctor Harris, as was I, was surprised by the answers given by Doctor Wecker as to whether stop date meant stop date or something else. He told me on cross, he equivocated, it means well, maybe something else. That meant we had to look and get under the data. One of the problems with crossing experts on this material, as Your Honor is aware, is that it's very hard for lawyers let alone the jury to understand what's at issue.

This witness has given testimony --

THE COURT: Is he using new data or is he not?

MR. STENGEL: He is not using any data which have not been in the hands of the defendants for six months.

MR. BERNICK: He's using new data. He's not using the extract. He's using some other raw data sources.

THE COURT: Excuse me.

MR. STENGEL: Your Honor, it may be more efficient just to have Doctor Harris explain to the Court what exactly he's doing.
THE COURT: We will do that outside the presence of the jury.
MR. STENGEL: Yes.
MR. BERNICK: Before that happens, Your Honor, in order for that to be informed, I would appreciate it if Your Honor would call Doctor Wecker. I believe that it would significantly inform the process of eliciting information from
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Doctor Harris.
THE COURT: All right. He will listen to Doctor Harris testify. Call -- I have another motion for a moment.
(Recess taken.)
THE COURT: All right. Would you get Doctor Wecker on the phone and ask Harris to come in, please.
You have twenty minutes to resolve whatever you are going to resolve. The jury is coming in at 10:00 o'clock.
Good morning, doctor, you are still under oath.
THE WITNESS: Thank you.
J E F F R E Y H A R R I S ,
called as a witness, having been previously duly sworn, was examined and testified as follows:
(Telephone call placed.)
MR. BERNICK: Doctor Wecker, we are in a courtroom full of people. Doctor Harris is on the stand. I have told the Court some of the circumstances surrounding our receipt of the computer disk and for the Court's information, have you had the opportunity to do a very brief review of those computer disks?
DOCTOR WECKER: Yes.
MR. BERNICK: Okay. I think that the Court is going to take some testimony from Doctor Harris so you have the opportunity to listen and maybe to make some comments after
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Doctor Harris testifies to the Court.
THE COURT: All right. If you can't hear, let us know and we will have people stand closer to the microphone.
Keep your voices up.
Proceed.
DIRECT EXAMINATION
BY MR. STENGEL:
Q. Doctor Harris, the issue before us right now is to what extent you use new data or information to respond to the criticisms that Doctor Wecker raised in his testimony of earlier this week. I guess the most efficient way to deal with this for the information of the Court is -- I am correct, that there are basically three criticisms you are responding to, the first is the CPS II comparison, the second is the selection of POC versus medical record quit date, and the third being the '63 break point and the interpretation of the scatter plot of claimant versus insulator quit rates?
A. That is correct.
Can you hear me? Doctor Wecker?
DOCTOR WECKER: Yes.
THE WITNESS: Thank you.
Q. If you could, Doctor Harris, focusing on what you have done analytically more than your conclusions, could you describe for the Court what you did -- strike that.

To what were you responding with respect to the
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CPS II analysis? What had Doctor Wecker done that you felt required a response?
A. I analyzed the data that Doctor Wecker had supplied in connection with his comparison of the Doctor Selikoff insulators with the men who participated in the CPS II study. My analysis was based on the data from the insulators which we both had in our possession, and the data that Doctor Wecker had supplied in connection with his analysis of the CPS II.
In addition, I also analyzed a computer run which was provided after lunch during the day of his direct testimony which he supplied.
I did not come up with or produce any new data from the CPS II or from the insulators or any other source in connection with that question which was not already in Doctor Wecker's possession or in the possession of the defendants.
Q. With respect to his -- we will call at this point lunchtime run for now, when did you actually get the data that he used to support that presentation?
A. Yesterday at about noon.
Q. All right. Let's turn to the issue of medical record quit dates versus POC quit dates.
Doctor Wecker made some fairly strong assertions with respect to your analytical work. Describe for the Court, again focusing more on the methodology and data than your ultimate conclusions, what you did with respect to those
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assertions of Doctor Wecker?
A. One of Doctor Wecker's concerns is that I misinterpreted the summary data that were provided from the medical audit that we all had in our possession more than a year ago. To resolve any such concerns, I looked at the raw data that was produced on each and every record, to see whether there was any missing information about quitting in the medical record. That raw data was also in the possession of all the parties, to the best of my understanding, more than a year ago, and when I went back in response to Doctor Wecker's concerns, I looked at that raw data to see in fact if I had missed anything.
Q. Was --
A. Beyond that, I know of no new data that I have analyzed that came from the audit, from any other source, that wasn't already in the possession, at least to my understanding, of all the parties more than a year ago.
Q. Now, was that inquiry prompted in part by a response by Doctor Wecker to my questions about exactly how he was treating stop dates out of medical records?
A. That is correct.
Q. That was given during his cross-examination yesterday or the day before?
A. That's my understanding, yes.
Q. All right. Let's turn to the third issue, which is the
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scatter plot of the claimants versus the insulators.
Do you have that question sufficiently in mind?
A. You mean, the pre-'63 versus the post-'63?
Q. That is correct.
A. Yes, I understand.
Q. You understood that that at least a chart reflecting that

data output was presented in court during Doctor Wecker's cross?
A. Yes, I do.
Q. Could you describe to the judge what, if anything, you did analyzing that data over the last few days and what data sources you employed?
A. Doctor Wecker did a comparison of the quit rates of the insulators versus the claimants pre-'63, pre-1963 as well as post-1963. I showed the results of that analysis not in a summary statistical form but on a year by year basis, and in doing so I used absolutely no new data. I simply rerendered the same analysis in raw form rather than in summary form.
Q. Going back to the CPS II analysis, we talked about the lunchtime runs. Were there other analyses or comparisons that Doctor Wecker referred to in terms of how he had looked for comparables by way of controlling for education and occupational group that you had not seen prior?
A. If I understand Doctor Wecker's direct testimony correctly, he testified that he had run other comparisons

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between the insulators and the men who participated in the cancer society study. However, in looking at all of the disks, all of the computer materials that Doctor Wecker had supplied to me over the past year, up until the lunchtime run, there was only one analysis of the insulators versus the CPS II that I could find, and that was the one that he presented on his direct testimony.

MR. STENGEL: Nothing further, Your Honor.

THE COURT: All right. Cross.

CROSS-EXAMINATION

BY MR. BERNICK:

Q. Doctor Harris, with respect to the CPS II rerun that you did, is it true that Doctor Wecker's original report in the case he did the comparison between the insulators and CPS II and set forth the results in his report?
A. Yes. As I understand it, you can't tell whether it was his original report or his supplemen --
Q. Yes or no would be terrific, Doctor Harris. Did he do that in his report?
A. He did it in one of his reports, yes.
Q. Was his report filed in June of this last year?
A. A supplement was in October 17. No. I am going to give a longer answer, if I may.

The actual CPS II data that he supplied that I could use in order to examine his results was not supplied to me

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until November the 6th.
Q. In his report in June, did he present a comparison between the CPS II data and the insulators and produce a curve reflecting the results?
A. Yes, he did. In one of his reports.
Q. Was that exactly the same curve that he -- was that exactly the same curve that he displayed to the Court in the direct examination in this trial?
A. I believe the curve that, or the results that he displayed to the Court were the results produced in his October 17 supplement.
Q. Do you recall that he was also deposed on exactly the same subject?
A. Yes.
Q. So both the curve and the fact of the significance of the

curve was available to you through Doctor Wecker's work substantially before this trial began, is that correct?
A. I think it would be fair to say that all of Doctor Wecker's work including the materials he relied on were available to me from approximately November the 6th on.
Q. In point of fact, what was new at the trial was that a plaintiffs' exhibit was introduced, Plaintiffs' Exhibit Wecker number 11, which showed a difference between CPS II and the insulators. Correct?
A. That's correct.

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Q. This is a curve that you generated, correct?
A. That is correct.
Q. When did you generate this curve?
A. About a week ago.
Q. About a week ago. Even before Doctor Wecker testified, correct?
A. I gave the --
Q. Was it before -- was --
A. It was before Doctor Wecker testified. It could have been less than a week ago. It could have been a few days ago.
Q. It was before Doctor Wecker testified; is that correct?
A. I think so. I could tell you exactly by looking at the date time stamp.
Q. Who asked you to make this?
A. Who asked me to make this?
Q. Yes. Who asked to you to do the graph?
A. I did it myself. Nobody asked me.
Q. You just did it on your own?
A. Yes. That's -- that's my graph. Nobody said go do that.
Q. The data to support this graph was not supplied to us until the lunch hour after the graph was used with Doctor Wecker, correct?
A. No. The data on which that relies on you had all along.
Q. No. The program run, Doctor Harris, the program run to support this graph was given to us during the lunch hour,

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correct?
A. That I don't know. I wasn't here.
Q. When you say the new run that was done by Doctor Wecker during the course of his redirect examination, that was a run that was done in response to the new graph that was used on cross-examination, correct?
A. That you would know. I wouldn't.
Q. Let's talk about the -- let's talk about the proof of claim data. Also with respect to the proof of claim data, Doctor Wecker's reports have said since day one that he had a criticism of how you determined the quit rates based upon the proof of claim, correct?
A. Correct.
Q. In fact, in your deposition you were deposed on exactly that very same subject, were you not?
A. Correct.
Q. On direct examination he made exactly the same point about the proof of claim that he did in his report, correct?
A. Correct.
Q. Okay. Now, you say that you have not -- you were careful when you talked about CPS II, the CPS II work that you have now done you say is based upon the same data that Doctor Wecker used; is that correct?
A. That's correct, yes.

25 Q. By contrast, the proof of claim work that you do is based
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1 on what you now call raw data, correct?
2 A. Yes. That's correct.
3 Q. Isn't it true that the proof of claim program that you
4 ran that supports the model that was presented to this jury is
5 not based upon that raw data? It is based upon a different
6 data -- set of data, a different extract, true?
7 A. Correct.
8 Q. Okay. Is it also true that you have never, ever produced
9 to us any computer runs for purposes of your model that have
10 been based upon this new raw data that you have now worked on
11 and given us computer disks on, is that correct?
12 A. That's correct. That is the raw data rather than the
13 summary.
14 Q. When it comes to the '63 jump, the '63 jump, the '63 jump
15 itself was also a matter that was criticized in Doctor
16 Wecker's report, is that correct?
17 A. Yes.
18 Q. It was a matter that was discussed with him in his
19 deposition, correct?
20 A. Correct.
21 Q. As well on that point his direct examination simply
22 pursued exactly the same matters that were in his report,
23 correct?
24 A. Correct.
25 Q. Okay. The year by year analysis, you say you have done
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1 year by year analysis of that data, correct?
2 A. Correct.
3 Q. Isn't it true that you specifically told us in your
4 deposition under oath that the insulator data was not
5 sufficiently robust to permit a year by year analysis?
6 A. I -- yes, but for a different purpose. That is, a
7 one-year versus the other year. But that's not what I am
8 doing. I need to give more than a yes or no answer to that,
9 sir.
10 Q. You told us that the data set was not sufficiently robust
11 to do year by year analysis, isn't that what you said in your
12 deposition?
13 A. Year -- when year by year analysis means deciding whether
14 the insulators quit rate in 1962 was any different than in
15 1963, no, one couldn't do that. But to decide whether the
16 pre-'63 quit rates as a whole are different than the post-'63
17 quit rates, then in fact elucidating the raw individual data
18 only helps.
19 Q. Representation was made to us by counsel when this graph,
20 Plaintiffs' Wecker Exhibit 11 was produced, a representation
21 was made that the -- a hard copy was given to us and the
22 representation was made that the hard copy of the program
23 supported this graph. Were you aware of that?
24 A. I supplied all of the materials that I used to generate
25 the graph. That's all I could tell you.
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1 Q. You don't know what hard copy was furnished to us during
2 the lunch hour or whether it matched the computer disk we were
3 provided?
4 A. I don't know what you were supplied, sir.
5 Q. Okay. With all these calculations that you have now done
6 on the proof of claim, you have not only used raw data, you

have run a whole new series of programs, correct?
A. I have run programs that you haven't seen. There are variations of previously supplied programs.
Q. Programs that we have not seen.
A. Correct.
Q. How many programs have you run to determine the quit rate of the claimants versus the insulators, how many programs have you run that have not been disclosed to us?
A. None.
Q. None?
A. None. Every program I have run, you have.
Q. Including the one that was sent to us last night?
A. Correct, yes.
Q. Okay. In that new set of programs, how many new programs have you developed and sent to us last night?
A. Basically there is one program that I broke up into six pieces. But it is one.
Q. One program, six different runs?
A. No. You have -- I tend to write programs and break it

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down into pieces so that if there is a mistake along the way, it doesn't propagate. But it is one -- basically one analysis.
Q. Isn't it true that you have developed not one new quit rate difference but three new quit rate differences that we have never seen before?
A. No. The answer is, there is one quit rate difference and then there are what I would call sensitivity analysis to show what would happen if you did something in the extreme.
Q. Tell me, sensitivity analysis, not sensitivity analysis, tell me how many different new quit rates come out of the computer program that you supplied last night?
A. Four.
Q. Four.
A. Let's see, one, two, three, four. Four all together if you count everything as a possibility.
THE COURT: All right. Stop.
You've got five minutes. Did you want your witness?
MR. BERNICK: I want to have my expert be able to comment to the Court.
THE COURT: All right. Have him comment.
MR. BERNICK: Doctor Wecker, if you could just describe for us the magnitude of the new information that you have received and also describe for us the -- the amount of work that would be necessary to prepare for an examination of

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Doctor Harris with respect to the information that you have received.
DOCTOR WECKER: Okay. There are nine new programs involving hundreds of lines of code that I have not seen before and which are not simple modifications of a previous program. I know this because I have put them through a red line program trying to find something similar and I have nothing similar. They involve four new approaches and four new calculations that lead to four different quit rate comparisons. They involve a new, I understand now being called raw data set as an input that was not provided. That data set that was described by Doctor Harris as in the possession of all parties to the best of his understanding was not provided, has never been provided by Doctor Harris or anyone else to us.

So the first thing I would need to do to begin to analyze this is get them to be cooperative in providing that data set. I would then have to understand what that data is, what it means, how it was collected, what a proper understanding of it is, figure out what the choices were that were made by Doctor Harris and why perhaps with some motivation he's making this so I can understand what he is doing. I would hope that would mean we could get a deposition on that subject.

The total amount of time that I would estimate to do

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this would, with good cooperation, would be about a month's work with six to ten people.

MR. BERNICK: Just to give the Court a flavor for that, have we been through this process before with Doctor Harris?

DOCTOR WECKER: Yes. We have been through a total of seven different reports. Each making changes to the one before. So I have had some experience of how long it takes to get to the bottom of these rather intricate calculations.

THE COURT: All right. Thank you, doctor.

I don't want any new data based upon an analysis of the raw data. Anything else is okay. You can't go back to the raw data because you didn't rely on that up until this date. Right?

THE WITNESS: That is correct.

THE COURT: Okay. That's the way it will be. Anything else you can testify to.

If you want to bring in a defendants' witness Tuesday, I will hear him.

MR. BERNICK: Here is what I would propose, Your Honor, to move along. There is no way, given whether new data or not that I can pursue CPS II or the pre- or post-'63 in a meaningful way. I have just received this information last night. What I would propose -- what I would propose is that we proceed with the witnesses that we intended to proceed

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with. If they want to call Doctor Harris to pursue those two items next Tuesday, they can do it. We will respond next Tuesday and that will be it. It will be a traditional --

THE COURT: I would think it would be better since he is here to have him testify on direct and then you can cross-examine as you wish Tuesday.

MR. BERNICK: But that all just means, amounts to the same thing. The effects of that really is that it's on our nickel. The jury is going to be blaming us this afternoon for not finishing.

THE COURT: No. They won't. They will blame me. I will take the blame. They believe me when I say it is my fault. If you don't want to do it, it gives you the weekend to go over and you've got him with some firm direct.

(Continued on the next page.)

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MR. BERNICK: I understand that. I think I understand what the court is saying. I think that the proper way to do it, given what has taken place -- I don't want the jury to get his direct examination and then all of a sudden we get to cross-examination --
THE COURT: You would want him brought in Tuesday?
MR. BERNICK: I want him brought in Tuesday as part of their rebuttal case.
THE COURT: Excuse me. Can you come in, Doctor, on Tuesday? I know you have other things.
THE WITNESS: I am available to the court, and I will make the changes. My conflict is my problem.
I do have a question, what it means to rely on the so-called raw data. If I'm stepping out of line, I won't ask it.
THE COURT: Not at all.
THE WITNESS: I'll be happy to testify about it.
THE COURT: Okay.
THE WITNESS: Dr. Wecker expressed a concern that I have misinterpreted the summary data on the medical record, which I regarded as the gold standard for determining who quit and who didn't in the claimants.
To attempt to resolve that, he ran a run in which he excluded from the medical record analysis anyone at all with what he regarded as an incomplete record.
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When I read the colloquy, or the question and answer, on his direct examination, he testified that he had excluded about a thousand records in doing so. In fact, it was 1,292 I intended to testify to.
You had asked him, in eliminating that more than a thousand, is there any reason why that population might be skewed? Those with your words. I intend to testify, if permitted, that the correct answer is absolutely yes. There is overwhelming evidence that the vast majority of those people eliminated in such an analysis were people that likely continued to smoke and that those who remained were quitters.
However, my conclusion that that is true is based not only on the summary information already there, but by my going absolutely back to all the information in the medical record to make sure.
THE COURT: Excuse me. That's okay, as long as there is no runs.
MR. BERNICK: Your Honor, that leaves us in an impossible situation.
THE COURT: Excuse me. Your witness made some statements there and he's entitled, isn't he, to meet them?
MR. BERNICK: Absolutely not --
THE COURT: Excuse me. It's 10:00 o'clock. I will take this up with you further later.
THE WITNESS: I'll be prepared to testify that
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looking at every source --
THE COURT: You be prepared to testify. Whether you will or not I'll have to discuss with you.
THE WITNESS: Thank you.
MR. STENGEL: I do want to clarify --
THE COURT: I don't want any clarification. Step

down, sir. 10:00 o'clock Monday.
Bring in the jury. Have your next witness.
(Witness excused.)
MR. BERNICK: Do we have the new numbers?
THE COURT: Dr. Harris, will you be available over the weekend for a deposition if they need something?
Do you want a deposition, yes or no?
MR. BERNICK: I do not want to put -- I do not want a deposition --
THE COURT: Okay.
MR. BERNICK: It puts me in a position --
THE COURT: Excuse me. Bring in the jury.
MR. BERNICK: What I would ask your Honor, instead of putting it to me like that, can we have over lunchtime or a break to take up the matter in due course?
THE COURT: Yes.
MR. BERNICK: Thank you. Remove this easel, please.
(Jury present.)
THE COURT: Please be seated everybody. Good

morning.
JURORS: Good morning.
THE COURT: If I may have your attention.
We will not finish the testimony today. We will finish it Tuesday, I hope; if not Tuesday, it will be Wednesday, not because of any failure on behalf of either of the counsel, all of the counsel, or of any of the witnesses, because of certain rulings that I have made while you were away. So any blame for further extension of the trial should be placed on the court.
As a reward, you'll have your lunch supplied by the government today.
Call the next witness.
MR. BERNICK: We apologize to the court and the jury. I want to quickly make a transition here.
(Pause.)
MR. BERNICK: We will call Dr. Fred Dunbar to the stand.
THE COURT: Good morning, Doctor. How are you?
THE WITNESS: Good morning.
THE COURT: You have testified before, haven't you, here?
THE WITNESS: Yes, I have.
THE COURT: You are still under oath.

F R E D E R I C K C. D U N B A R,
called as a witness, having been previously duly sworn, was examined and testified as follows:
DIRECT EXAMINATION
BY MR. BERNICK:
Q. Good morning, Dr. Dunbar.
A. Good morning.
MR. BERNICK: Good morning, ladies and gentlemen.
JURORS: Good morning.
Q. Dr. Dunbar, we're going to talk here today about whether the Manville Trust paid for tobacco.
A. Yes.
Q. Okay. Let's give the jury a little bit of introduction to you and your background. Could you tell us where it is that you work.

A. National Economic Research Associates.
Q. And could you tell the jury basically what that organization is.
A. It's a group of consulting economists. Most of us are former academics who, for one reason or another, like the life-style of consulting. There are about 400 people in 13 offices worldwide.
Q. What's your position there?
A. Senior vice president.
Q. Do you also have an adjunct professorship at Columbia

University?
A. Yes.
Q. I would like to show a little chart to give the get the jury into your areas of expertise. Showing you DEM 12128. Does this reflect your areas of expertise?
A. Yes, it does.
Q. Could you just talk a little bit about what your background is in each one of these areas.
A. Yes. In terms of my educational background, I went to college, where I majored in both mathematics and economics. I did that on scholarship and working in a plywood mill to may the tuition.

From there I went to -- that college gave me a BA, and then I went to graduate school at Tufts University on a National Science Foundation grant, where I got an MA and a Ph.D., both in economics.

I taught there for awhile and then I went to help form a graduate school in economics at Northeastern University, and there I taught mainly the mathematical areas, such as he econometrics, statistics, mathematical economics.

I left there to pursue policy research, applying my statistical and economics background, and in 1979 I joined the firm of National Economic Research Associates.

We were purchased in 1983 by a firm called Marsh & McClennon, which had a business of providing advice to

companies on risks, insurable risks, such as product liability or if somebody were to sue from falling down in the plant and breaking a leg, that sort of thing.

As a result of that, I was able to work with them and their clients in order to try to get a grip on what the future lawsuits against those companies would be in various areas.

We call that claims estimation, those are claims that are going to be made against a company. So I have been doing that for about the last seventeen years.
Q. Have you published articles in your field?
A. Yes. I have about twenty-five peer-reviewed articles and about fifty or sixty other items that appear in trade press or invited publications, and I have one book.
Q. We'll talk about the book in a moment. Have you taught statistics and economics?
A. Yes. That's what I taught at Tufts and Northeastern.
Q. Let's get to the book. I have -- it's not even out of the wrapping, Estimating Future Claims. Case Studies for Mass Tort and Product Liability.

Is this the book that you have written?
A. Yes, it is.
Q. You've mentioned the word estimation, claims estimation as one of the areas of expertise. I want to focus on that a little bit.

25 The jury has heard from statisticians, they have
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1 heard from economists, I don't believe they have heard from
2 anybody who has practiced within the field of claims
3 estimation. Could you tell us what it is that claims
4 estimation involves.
5 A. Yes. Very often a company has produced a product which
6 is going to create a problem for them. They may not know that
7 in advance or they may know about it at some point when some
8 lawsuits come in, and what the claims estimation does is it
9 gets into determining -- it tries to answer the question of
10 how many lawsuits are going to be filed against the company,
11 and then what's going to be the cost of resolving those
12 lawsuits, both in terms of litigation expenses and also in
13 terms of the payments that the company is going to have to
14 make to the plaintiffs who are suing them.
15 Claims estimation involves figuring out such things
16 as the number of people who used or were exposed to the
17 product, from those number of people, how many suffered some
18 injuries, such as a health problem or a damage to their
19 property, and then how many of those will make a claim --
20 actually a relatively small percentage tend to make a
21 claim -- once that claim is made, how is it going to be
22 resolved -- will it go to trial? Will it be settled? -- and
23 then how much is the company going to pay.
24 Q. Have you given seminars in the field of estimating
25 claims?
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1 A. Yes, I have.
2 Q. The book, is that a book about the estimation of claims?
3 A. Yes, it is.
4 Q. Is DEM 012129 a list of claims facilities that you have
5 analyzed during the course of your professional career?
6 MR. BERNICK: Sorry. Would it be possible, while we
7 have the testimony going, if we could have a little bit less
8 activity on the table here? I'm sorry.
9 Q. Dr. Dunbar, could you just go through the claims
10 facilities that you have analyzed?
11 A. Yes. One way, established actually in this court on
12 Agent Orange, I worked on the issue of who would be the best
13 organization, the Aetna insurance Company, to manage the
14 claims processing.
15 I worked on what has become known as the Center for
16 Claims Resolution, which was a group of about twenty asbestos
17 manufacturers who got together to sort of reduce the cost of
18 managing asbestos exposure.
19 I have analyzed the breast implant, MDL,
20 multi-district litigation. That was a facility developed by a
21 court in Northern Alabama to deal with breast implants.
22 I have also had to analyze the Dalkon Shield Trust,
23 which paid claims to women who were injured by the Dalkon
24 shield device. And I have analyzed the claims and values for
25 twelve asbestos manufacturers.
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1 Q. These are all situations in which it is the product that
2 cause injury, the injury causes claims to be filed, and your
3 role is to get involved in understanding what kinds of claims
4 are being filed, the value of those claims, the future
5 projections of those claims. Would that be a fair
6 statement?

A. That's a very fair statement.
Q. Okay. Let me take a look at other claims estimation work. DEM 012030. Are these other areas where you have done claims estimation work?
A. Yes. DES was a product to prevent premature labor in women. It turned out to cause problems in babies. Chemical manufacturers often have a wide variety of products, everything from Saran Wrap to cement that might not work.
I have estimated claims for air bags even before they were introduced because the manufacturer felt that there might be might be some future liability from air bags that didn't work and injured people.
American Club is the group that insured the maritime industry, and they had to pay asbestos claims. H.K. Porter is an asbestos manufacturer. Hardboard siding was a product that kind of degraded in the rain, was not a very good idea in the Northeast and Southeast on houses.
Synthetic stucco has basically the same problem, works very well in Las Vegas but not in the Southeast.

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Q. Let's talk about tobacco. Have you ever been retained to act as an expert witness in tobacco litigation?
A. Other than this?
Q. Yes.
A. I am -- I have been retained in at least two other matters.
Q. They are related to -- what period of time does that involve?
A. Over the last year and a half.
Q. The last year and a half. Is this the first time that you've testified in a case involving tobacco?
A. In court, yes.
Q. Let's go to some of the basic methods that you use in claims estimation.
Is DEM 012131 a brief recitation of some of the methods that are involved?
A. Yes, in fact this follows a fairly typical sequence that we would go through. Even though ultimately the work I do has to involve numbers because management really wants to know what the dollars and cents are for their future liabilities, I have to get an understanding that goes beyond that in the initial phase.
I have to understand the process at work. If it's a case of a medical problem, I have to get an understanding of what is called the epidemiology, and I have to get an

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understanding from the claims facility of how they go about handling these claims, how they deal with their adversarial relationship with the plaintiffs.
So that causes a review of historical documents and, if I'm working for a firm, then I usually have extensive interviews with the legal staff, the claims handlers, maybe the technical people.
In a case of litigation, sometimes I don't have access to the people who are involved in the facility because they are on the other side, so in that case I rely on deposition testimony, which is the lawyers ask the questions that I would like to have answered in a deposition, and then I review the deposition testimony.
Data preparation means that we have to try to get ahold of a database. Now, if it's kind of a mature situation,

like asbestos is, there are a number of claims databases that give you good historical information and then you can use those historical experiments to tell you what's going to happen in the future. Sometimes the data are not as good as you want and you have to go outside that and acquire more information.

Then we get to the statistical analysis, and basically what the statistical analysis does is it kind of puts together the first two steps.

Step one tells me what I think the kind of

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relationships, the correlations and things that I want to test are, and then I have the data in step two, and then in step three, I actually test what my beliefs are on the basis of reading the documents or talking to people, and I find out whether some relationships are reliable or unreliable, and I find out whether some things that I thought were reasonable are unreasonable and, ultimately I hope to be able to quantify these things so I can end up giving a dollars and cents answer to the client.

Then the last step is, once I have kind of a handle on what I think the correlations are, what I think these relationships are, I can make estimates based on other events happening, such as inflation or whatever is going on.

I'll try to estimate into the future what the situation will be or I'll try to make an estimate for management of what would have happened in the past had they pursued a different strategy, had they done something different, what would their exposure have been. So that helps them understand what they should be doing in the future.

MR. BERNICK: Your Honor, we would offer Dr. Dunbar as an expert in claims analysis and estimation.

THE COURT: He may give his opinion.

Q. Dr. Dunbar, again, in the same type of fashion, does DEM 012132 outline in general terms the tasks that you performed for this particular case?

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A. Yes. We had access to a lot of documents and deposition testimony, in the first instance. In the second instance, we had available to us the databases that the plaintiffs used, which were claims, samples of the claims that had been filed against the Trust, and also we had what was called the full extract, which is a database that has all of the Trust claims on it.

We were able, also, to get data out of files that the Trust had made, where there were notes about the settlement negotiations that they were going through with the plaintiffs' attorneys.

So those provided the primary sources of date. Then I did the statistical analysis to find out what was causing the money per claim that the Trust was paying. Then finally I was asked to look and see what would happen if there had been less smoking on those filings.

Q. To put it in kind of simple terms, you have a lot of quantitative analysis, statistical analysis, you got a lot of history.

Have you done your best to literally relearn the history of how the Trust operated in order to understand why it paid the money that it did?

A. Yes. Like I say, we were fortunate in that the Trust had a lot of documents that we could review for them.

25 Q. Okay. The jury has heard about the contribution of
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1 tobacco to asbestos-related illness, that asbestos-related
2 illness is caused in part by smoking.
3 Have you looked back to determine whether in settling
4 claims the Manville Trust as well as others sought to take a
5 discount or reduce the settlement value so that they wouldn't
6 pay for tobacco, have you looked into that?
7 A. Yes, I did.
8 Q. What have you found, just in general terms, was there or
9 was there not an effort by the Trust and indeed others before
10 them to reduce the settlement of claims being brought by
11 smokers so that they wouldn't be paying for tobacco?
12 A. Yes. The Trust and asbestos manufacturers did try to
13 reduce the amount that they would pay to a smoker because of
14 the effect of smoking on the plaintiff.
15 Q. How far back -- we know that the Trust came into
16 existence in 1988. Is there a term we can use just a
17 shorthand term that we can use to talk about this reduction in
18 settlements so that you don't pay for tobacco?
19 A. The Trust term is shared causation.
20 Q. Shared causation. We often talked about it in terms of
21 being a tobacco discount, or something to that effect?
22 A. Yes.
23 Q. Do you see that in the testimony of the witnesses as
24 well, that they talk about tobacco discount?
25 A. Right.
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page 5724
1 Q. Even before the Trust came into existence, was there a
2 practice of discounting claims by reason of tobacco?
3 A. Yes. The asbestos manufacturers were very conscious of
4 the defenses that they had, which included smoking, and so in
5 terms of the litigation value of a claim, a claimant who was a
6 heavy smoker had kind of a harder road to hoe in litigation
7 than a claimant, say, who was a nonsmoker.
8 So from the -- even from the seventies, when there
9 was litigation, there was a discount for smoking that occurred
10 in settlements to reflect what would happen if the case went
11 to trial, and people started writing about that discount as
12 early as 1980.
13 Q. Okay. We're not going to go quite back that far. But
14 have we prepared -- are you prepared to address this tobacco
15 discount from -- within periods of time over history in order
16 to explain how the discount came into the Trust and how it
17 affects the payments the Trust is even making today?
18 A. Yes.
19 Q. Showing you DEM 012160 -- I'm going over here at my
20 peril --, but we're not going to be making much use of the
21 chart in detail except to create a point of reference.
22 Does this chart break out the basic periods of time
23 during which tobacco discounting took place or was discussed?
24 A. Yes.
25 Q. Are we going to basically go through these basic periods
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1 of time here this morning as efficiently as we can?
2 A. Yes.
3 Q. Okay. Let's talk abut the period of time even before
4 1985. Have you found evidence that there were proposals that
5 were considered by the Johns Manville Corporation to take the
6 total value of a settlement and divide it up between asbestos,

on the one hand, and tobacco on the other?
A. Yes. It was actively discussed and written on during the bankruptcy proceeding. There was a proposal made in bankruptcy, and some of the details of that proposal were eventually published in the literature.
Q. Showing you ARF 001170, -- which is already in evidence, your Honor -- is this an article that was written and published by people from Johns Manville, basically talking about a way to apportion settlements to asbestos versus tobacco so that the tobacco portion would not be paid by Manville?
A. Yes. This came directly out of the bankruptcy negotiations that were going on.
Q. Let me talk about this just in general terms for a moment to give the jury a feel for different ways that this might be done.
We have heard testimony that if you take the total risk of asbestos-related illness -- I will call this whole pie as risk -- some substantial part of it is -- pick any one you

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want, say tobacco and asbestos -- some numbers created by the asbestos, some created by the tobacco, and there are some that is synergy, there has been testimony to that effect.
A. Yes.
Q. Is it possible, if you wanted to, to take the total value of a settlement and kind of divide the settlement dollars up by risk, if you wanted to do that?
A. Yes, it is.
Q. The approach that is described by Manville in the mid-1980's, is this an approach that is based in part upon the idea of allocating risk?
A. I think it's almost entirely based on risk, yes.
Q. There are some other considerations, the timing, whether it was pre or post warnings, things of that nature --
A. Because those things affect risk.
Q. Because those things affect risk?
A. Yes.
Q. Is it fair to say that the allocation or discounting method described here is a very complicated one?
A. This allocation method?
Q. Yes.
A. It is certainly something that is implemented. It's almost formulae.
Q. Is there a formula for it?
A. Yes.

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Q. So if you wanted to, you could take a formal formula and try to apply it?
A. That's correct.
Q. Could you also do this kind of allocation -- this allocation would result in a discount, wouldn't it?
A. Yes.
Q. That is, the asbestos company would pay this part, they wouldn't pay this part, they would pay less money?
A. That's correct.
Q. Is it also possible to do the same kind of allocation or discounting by negotiation?
A. Yes.
Q. So you have a formula here, but you may do it by negotiation, too?
A. That's correct.

(Continued next page)

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EXAMINATION CONTINUES
BY MR. BERNICK:
Q. Okay. Let's take the next period of time, which is the ACF. We have down here that the ACF predated the Trust, the Trust is 1988. That's not going to stay there very long.
The ACF existed prior to 1988. Could you tell the jury what the ACF was?
A. The ACF grew out of a negotiation that was held among most of the major but not all of the major asbestos manufacturers and a law professor at Yale called -- whose last name is Wellington. They came to terms among themselves and with the insurance companies for a way to deal with the lawsuits that were being made against them and that became known as the "Wellington Agreement."
Out of the Wellington Agreement came something that is called the "Asbestos Claims Facility," where the membership varied over time, but it usually it was in the high thirties, around forty members, and they would try to -- they would pool their resources in order to negotiate. The ACF would negotiate on behalf of all forty of them and then once it came to an agreement with an attorney as to what the -- should be paid to the asbestos claimants, the ACF would then divide up the money that had to be paid among the members, according to various formula.
So basically, they negotiated settlements with

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attorneys. They were in the tort system.
Q. Okay. So these are other manufacturers?
A. Yes.
Q. Other asbestos companies. And they are banding together, creating a facility and they settle a lot of claims?
A. Yes.
Q. This is all before the Trust even came into existence?
A. Yes.
Q. Do you know whether in the ACF, as the Asbestos Claims Facility settled cases, do you know whether they took a discount for tobacco?
A. They did.
Q. Are you familiar with the testimony of a Mr. Gregory Smith?
A. Yes, I am.
Q. Who is Gregory Smith?
A. Greg Smith was manager of the eastern region of the Manville Trust when they were negotiating claims in the preC and the post-C period.
He came to the Manville Trust from the ACF.
Q. Okay.
A. He was basically their chief negotiator for the eastern US.
Q. Did Mr. Smith also work not only for the -- I'm sorry.

25 He worked for the ACF as well?
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1 A. Yes.
2 Q. Okay. He then went over to become a worker for the
3 Trust?
4 A. Yes.
5 Q. He testified in this case, is that right?
6 A. Yes.
7 Q. The jury will hear this testimony. Did he testify about
8 taking a tobacco discount while he was with the ACF?
9 A. Yes, he did.
10 Q. Okay. Just to review briefly for the jury, this is page
11 15, line 22.
12 You testified before that you looked at the smoking
13 history of, I guess they would be plaintiffs who had made
14 claims against the Asbestos Claims Facility. Was the purpose
15 of looking at the smoking history to take a smoking discount
16 for the people who were smokers?
17 Answer: Yes.
18 Describe what a smoke discount is.
19 Answer: Well, I think different people arrive at
20 that in a different fashion.
21 We have talked a little bits about that, have we not?
22 A. Yes.
23 Q. But personally I would look at how many years they
24 smoked, how many packs per day they smoked, how long they had
25 been smoking, whether or not they had quit smoking and how
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1 long before that point in time they ceased smoking.
2 If I didn't mention it, what kind of cigarettes they
3 smoked, whether they be filtered or unfiltered cigarettes,
4 those sorts of factors.
5 Question, page twenty, line two: While you were with
6 the Asbestos Claims Facility, did you take a smoking discount
7 for lung cancer?
8 Answer: Yes.
9 Line 13: If a person was a current smoker and had
10 lung cancer, would you take a smoking discount for that
11 person?
12 Yes.
13 And I believe there is also testimony, was there not,
14 regarding asbestosis?
15 A. Yes.
16 Q. Page 21, line two. Would you agree with me that there
17 were circumstances where you would take a smoking discount for
18 a person who had asbestosis?
19 Again his answer is yes.
20 Tell the jury why it is important to this case that
21 the ACF took a smoking discount?
22 A. Yes.
23 In the -- what's called the preC period, the Trust
24 had set out as its goal to settle seventeen thousand claims
25 which were lawsuits that had been filed against Manville
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1 before the 1982 bankruptcy. The Trust wanted to settle those
2 claims before what was a called the consummation date of the
3 bankruptcy in November of 1988.
4 They started negotiating those claims, however, in
5 May of 1988, giving them a period of only a few months in
6 which to try to resolve what at that point was a fairly large

number of claims.
Q. So we are now in the Trust era. The Trust doesn't open its doors until November of '89?
A. '88.
Q. '88. And during this initial period of time, they are trying to negotiate a bunch of settlements?
A. That is correct.
Q. Okay. I am sorry to interrupt.
Continue.
A. So they hit upon the idea of using the ACF settlements as a way to serve as a kind of a yardstick for how the Trust should compute its claim values. What they did is they said well, the ACF has been settling these claims for about three years before us. Most of these claims have been settled by the ACF already, and so we will take a share of what the ACF settlement was. A little more complicated than that, but basically that's it. They would take a proportion of the ACF settlement and use that to negotiate a settlement for the Manville claims.

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So what that meant was that if a smoking discount was given in the ACF, which it was, then that smoking discount would flow through to the negotiated Manville claim, because Manville is just taking a constant proportion of the claims, be it's a smoker or a non-smoker.
Q. Okay. Before I ask you to explain that a little bit, again, did Mr. Smith, Mr. Smith used to work for the ACF, he came over to the Trust and did he -- was he one of the people principally responsible for settling claims in the preC period of time?
A. Yes, he was.
Q. Did he describe exactly what you have described, that is, the carry through of the tobacco discount to the preC settlements?
A. Yes.
Q. Showing you page 40, line one. Would you agree with me that by using the ACF data to determine the appropriate amount of payment to the claimants, that implicitly -- that implicitly a smoking discount was taken because the ACF had taken a smoking discount?
Answer: If you're working from the same bottom line and in fact a smoking discount had been taken, it would have been taken into account, yes.
Is that exactly what you have talked about here?
A. Yes, it is.

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Q. Kind of put real simple, ACF terms a dollar figure for a claim. It takes off the top tobacco. That dollar figure carries over to the preC settlement of the Trust. What's happened to the tobacco dollars? Are they paid by the Trust or are they not paid by the Trust?
A. No, they are not paid by the Trust.
Q. Was that practice followed uniformly during the preC period of time?
A. Yes.
Q. Are we going to eventually get to a calculation of how much money was involved?
A. Yes.
Q. Okay. Let's talk about the post-C period of time. During the post-C period of time the Trust has now opened its doors. Let me ask you, how many claims were settled preC

16 approximately?
17 A. In the fifteen thousand range.
18 Q. Post-C period of time, trust now opens its doors and it
19 starts to process claims on its own.
20 Is that fair?
21 A. Yes.
22 Q. During the post-C period of time, did the Trust follow
23 the same practice, that is, to use the ACF prices or not?
24 A. No.
25 Q. Tell the jury what it is that the Trust did once it
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1 opened its doors.
2 A. What the jury did was evaluate each claim individually
3 and they had people working in the claims facility who would
4 look at the data and information that was provided by the
5 plaintiffs' attorneys for each claimant, and they had at the
6 end of the claim form a summary sheet where they would
7 figure. They would work out the figures. Immediately try to
8 figure out what they called the gross value of the claims,
9 based on such things as lost compensation, pain and suffering,
10 those things that go into what the value of the claim, and
11 then they would take the next thing they would do after they
12 figured out the gross value is they would take off a
13 percentage for a smoker that they called "shared causation."
14 If a person smoked, they would take off 20, 50
15 percent of the gross value before they would go down to
16 figuring out the -- what the Manville recommended settlement
17 number would be.
18 Q. Now, how many claims in total were being processed or
19 were processed during the post-C period of time, do you
20 recall, roughly?
21 A. Ten to twelve thousand.
22 Q. Ten to twelve thousand post-C claims?
23 A. Yes.
24 Q. To do an individual evaluation for ten to twelve thousand
25 claims, would it be fair to say that you need a process for
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1 that?
2 A. Yes.
3 Q. The process that was followed, is that something that had
4 to be pretty formal at the Trust?
5 A. It was written out. You could follow objectively what
6 claims evaluator had done because they wrote out their
7 thinking.
8 Q. So when you are here to talk to us about how a tobacco
9 discount was taken, is that something that's actually written
10 down?
11 A. Yes.
12 Q. Showing you GZ, G as in George, Z as in zebra, 200053,
13 which is already in evidence. Is this the first page of the
14 evaluation manual or form here? Instruction?
15 A. Yes.
16 Q. It stays the evaluation of a claim calls upon all of your
17 training.
18 This is an instruction to the claims people?
19 A. Yes.
20 Q. All of your training, knowledge and experience and is the
21 culmination of all the fact finding efforts on the case at
22 hand. It is the place where all of the loose strings, various
23 aspects and unique features of a claim are pulled together to
24 form a cohesive and logical bird's eye view of the case to a

25 reserve at a reasonable dollar value for the claim.
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page 5737
A procedures manual is not the forum to explain how to evaluate a case. That involves months and months of intense training and experience. It then goes on to talk about the fact that an example though is provided. It says on the following page is an example of the evaluation section of the CAS which may be useful to refer to as you read the following text.
We then have the next page as an example. I don't know if the jury can see. This is a case where you have a hundred pack year smoker with upper low -- upper lobe adenocarcinoma, ten years exposure to PCBs, only underlying disease is pleural plaques, and you then get a discussion, you get a whole bunch of lost wages, costs, and then a total, a gross settlement value. What was the gross settlements value?
A. Six hundred thousand dollars.
Q. That means that the whole claim is worth six hundred thousand?
A. Yes. In terms of damages to the claimant.
Q. So we have total value is six hundred thousand dollars. But it then says minus. Shared causation two hundred forty thousand. So we've got two hundred forty thousand of shared causation, and it also subextracts out 70 percent Manville.
Is that right?
A. Non-Manville.
Q. Actually, non-Manville.
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How is that -- this is the percentage of the deductions. So you've got two hundred forty thousand, two hundred fifty thousand, kind of the same amount. What does non-Manville mean?
A. After they have subtracted out the two hundred forty thousand, leaving about four hundred sixty thousand there, they then would take off another share for what they believe was the responsibility of other asbestos manufacturers. They would say that our, in this particular instance, our responsibility is only 30 percent and the other manufacturers' responsibility is 70 percent, so they then take 70 percent of that number I just gave, whatever it was, three hundred some odd thousand.
Q. Okay. So you have two hundred fifty-two comes out for basically other asbestos?
A. Correct.
Q. Then you have another deduction for other discounts it says PCBs?
A. Yes.
Q. That's kind of another sliver, for another factor that may be responsible, PCB's. What's left over is the recommended settlement for what?
A. Yes. They add in a little bit here for dependent. That's basically right.
Q. It is for Manville.
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A. Yes.
Q. The idea is you go through the total value of the claim. You then figure out, take out shared causation, take out non-Manville, take out special factors, and you are left with what the Trust is going to pay?
A. Correct.

Q. This shared causation, is the shared causation actually described?
A. Yes.
Q. Turning to another page of the document. It says next comes several deductions. Shared causation almost always refers to the smoking discount.
After reviewing the smoking history and considering its effect on the claimant's disability, the CSN should indicate the discount as a percentage. A smoking discount should be considered on every other type of claim. That is, aside from mesothelioma.
Is that right?
A. Correct.
Q. Okay. This process, the process that we have described in the document here, is this also -- was this also described by Mr. Smith in his deposition?
A. Yes.
Q. Did he say that this form was in fact followed?
A. Yes.

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Q. I'm sorry. I want to get the reference to the -- there is a reference to some notes and in talking about the amount of the discount, the question at line -- page 68, line ten, or actually, line 14: Do you see that it says that the range of discounts is 25 to 75 percent?
Answer: Yes, I see that.
Question: Is that consistent with your view of the range -- you see where it says -- is that consistent with your view of the range of a discount for a lung cancer?
Answer: That is consistent with the range that you would tell people to look at. It is not necessarily consistent with the actual discounts taken over a period of time.
Question: Do you have a view as to what the actual range of discounts were over a period of time?
He then says at page 69: The only thing I could say was probably somewhere within this range, but where, I don't know.
Are we going to find out where it actually was?
A. Yes.
Q. Okay. So Mr. Smith confirms that the discount was taken?
A. Yes.
Q. Have you actually looked at the claim forms themselves to see if the shared causation discount was taken?
A. Yes, I have.

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Q. Showing you GZ-200072. Is this a series of CAS forms that were actually filled out?
I will show you page 0020049. Is this an example of the filled out claim form?
A. Yes.
Q. You see you have the gross settlement value. That's just like that we talked about, six hundred thousand? This is two hundred fifty-eight?
It says minus shared causation. Here it is explicit. For example, smoking.
Does that again reflect there was a smoking discount?
A. Yes.
Q. Here is another one, page 0020054, again, is that another example?
A. Yes, it is.

Q. Page 0020059, another example?
A. Yes.
Q. They vary?
A. They -- in this particular batch, they vary almost directly proportionate with the pack years.
Q. Pack years. Pack years is basically a measure of how many packs people have smoked and over what period of time?
A. Exactly. If you are a one pack a day smoker over twenty years, that would be twenty pack years.
Q. Here the discount is 15 percent of the gross value.

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A. This might have been the hundred pack year.
Q. The hundred pack year person. That's a very substantial discount?
A. Yes.
Q. Okay. Now, again, when the Trust decided to do these discounts on a case by case basis, if they wanted to, they could have used a risk-based formula, could they not?
A. Yes.
Q. Did the Trust choose to use some sophisticated statistical model or risk-based approach?
A. No, not in this period.
Q. Are you familiar with what Mr. Austern said was the reason why?
A. No, I am not.
Q. Okay. It was part of his testimony.
Let's review this approach a little bit. This is DEM-012133. This is kind of a prettier version of I think what we have talked about here.
I think we are going to try to get a different screen in here. It might be a little bit clearer. It is hard to read.
Does this basically describe the big pieces of the puzzle in figuring out what it is that Manville Trust actually paid for?
A. Yes.

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Q. You have talked about in your example here non-Manville asbestos. Did the Manville Trust take pains to avoid paying for the portion of the claim that was felt to be caused by somebody else's asbestos?
A. Yes, it did.
Q. Did the Manville Trust take pains to avoid paying for shared causation, including specifically tobacco?
A. Yes.
Q. What was the only portion of the total value that was actually paid by the Manville Trust during the pre- and post-C periods of time?
A. That which was attributable only to Manville.
Q. Let me show you testimony of doctor -- of Mr. Austern in this trial, at page 2201.
Question, line ten: Isn't it true that the Trust also deducted from total value shared causation?
Answer: It did.
Question: Therefore, that the recommended, the recommended Manville trust settlement was what was left over at the end?
Answer: Is that a question?
Question: Yes.
Answer: I am not sure I would describe it that way. What was left over at the end was a negotiation number.

I say fine.
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Isn't it a fact that shared causation was defined by the Trust's own documents to be tobacco?
Answer: That was certainly one of the shared causations and I have no doubt that you can show me a form that did just that.
Then at 2202, during the post-C period of time, the Trust deducted other asbestos, right?
Answer: Other asbestos companies' liabilities.
Other companies and it also deducted tobacco, right?
Answer: As part of shared causation.
Is that consistent with your own view?
A. Yes, it is.
Q. I then asked him this, page 2205, your legal responsibility, as you understood it, as you told all of your people, was to exclude share causation, true or not?
Answer: If you could in the negotiations to that.
Is that consistent or inconsistent with your understanding of what actually occurred?
A. That's consistent.
MR. BERNICK: At this time, Your Honor, we would like to request for admission number 85.
THE COURT: Yes.
MR. BERNICK: In this case. This is a request for admission, where the defendants put a formal question to the Trust and the Trust answered it in this case.
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Requests for admission -- admit number 85.
Admit that the Trust is not empowered to pay anything more than Manville's liability for asbestos related injuries.
Do you see that?
A. Yes.
Q. It's admitted as the court that oversaw the bankruptcy determined.
Now, I asked Mr. Austern about this. I asked him well, the recommendation to take the discount, was it in fact taken?
I asked him that, 2237. As you sit here today, you don't know what portion of that recommended deduction in fact was taken by the Trust, do you?
Answer: No, I do not.
Have you, Doctor Dunbar, determined with respect to the recommended amount for discounts how much in fact was actually taken?
A. Yes, I have.
Q. Could you tell the jury how you have gone about doing that? I know you have done it in a couple of different ways.
A. First of all, in the statistical data that I had the Trust's own files, we had a sample that had been drawn by the plaintiffs and on that sample we had those claims analysis summaries that had those lines filled out on them, and then also in the time, if you read either the form or you went into
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the file, you would know the number of pack years or the duration of smoking if it was a smoker that the -- that was attributed to the claimant.
So the first thing we did is we tried to see if there was a correlation between the smoking which was reported and the shared causation which was computed, and we found a very

high correlation between pack years and the amount of the shared causation discount.

We also then went and just computed the average of what the smoking discount was off of those claims analysis summaries for both lung cancer and for asbestosis. In the case of lung cancer, that average was 26 percent; and in the case of asbestosis, the shared causation amount averaged 14 percent.

We also took -- from the sample we computed an average for non-smokers that were also lung cancer claimants who had both a recommended amount and a paid amount on the form and we compared that to the average for smokers, and we did that because we found a document in the files where somebody had upon analyzing six thousand records recommended one hundred twenty thousand for non-smokers and seventy thousand for smokers. We came up with our smaller sample of about a hundred and eighteen thousand for non-smokers, and about seventy-two thousand for smokers.

That gave us comfort, that we had found something in

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the same range that had been found by another expert in another court proceeding using the Trust's data.

Another thing that we did was we said well, if you compare simple averages, one of the problems with that is you may be making apples versus oranges comparisons. Somebody -- you may have a non-smoker, for example, who has a lot of dependents and you are comparing that to a smoker who has no dependents. The non-smoker could have higher values because they have dependents rather than because they are a non-smoker.

What we did was we tried to match claimants up against each other on like versus like categories. We call that a matched pair sample. We would match people up on law firm. They had to have the same law firm.

We matched them up on jurisdiction, from the same geographic area. They had to have negotiated within ten percent what the Manville share was for that person, and they were matched up on other issues -- disease, dependents, that sort of thing.

We found a statistically significant difference in that matched pair analysis between smokers and non-smokers for both lung cancer and asbestosis, and the difference in the medians that we found was similar to the averages that we were computing off of the CAS forms.

Q. With respect to lung cancer in particular, what did you

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determine, showing you DEM-012135 regarding the prices or the values that were paid for claims brought by non-smokers versus claims brought by smokers?

A. Yes. I mentioned before that there was this other expert who had been working in a prior proceeding around 1990, Mr. Peterson, and he found that a non-smoker, or he recommended on the basis of an analysis of six thousand claims that a non-smoker should be valued at one hundred twenty thousand for Manville and a smoker at seventy thousand, and when we did our own calculation from a sample of claims that had been drawn by the plaintiffs in this case, again, where we had both recommended and paid amounts, these are the averages that we found.

We found a hundred eighteen thousand five hundred for a non-smoker and seventy-two thousand five hundred

seventy-nine for a smoker, which was very close to the recommendations of Mr. Peterson.
Q. Now, if you wanted -- if the trust wanted to avoid paying for tobacco, was it critical that they do it in this way or are there other ways to achieve the same basic result by aggregating the total amount and taking off an aggregate amount? Do you have to go this way or is this just one way of doing it?
A. This is just one way to do it.
Q. Have you determined on a percentage basis for lung cancer
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the portion of the total value during the pre-TDP period of time, the portion of the total value that was paid by Manville?
A. Yes.
(Continued on the next page.)
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Q. Do we have it here on this chart?
A. Yes, we do.
Q. During the pre-TDP period of time, did the Trust pay for anything other than the Manville Share?
A. Not that I could find out.
Q. During the pre-TDP period of time, did the Trust pay for shared causation for lung cancer?
A. It did not pay for that. It took that as a discount.
Q. With respect to asbestosis, showing you DEM 012136, is this the same basic type of chart for asbestosis?
A. Yes, it is.
Q. Now, let me deal with something that --
MR. BERNICK: After this may be a good time for a break, your Honor, we're going to go to another subject.
Q. One issue I want to take up, Dr. Dunbar, is a little bit tricky to deal with.
There has been a claim in this case, Mr. Austern has testified through deposition that the Trust knew even before it opened its doors that there were going to be more and more serious claims against the Trust, more and more serious claims because people smoked. I want you to assume that. It was shown to the jury yesterday. Mr. Austern and the Trust knew that.
So I want you to assume that there were more

claims -- I know you've done an analysis -- more people
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because they smoked got asbestos-related illness.
How could it be that if all the Trust did was to take a discount on each claim, how could it be that they wouldn't end up paying more because there are more claims?
Did I pose the question the right way?
A. That is in fact the very reason that they take the smoking discount. If you have a number of -- more claimants because they are sick from either asbestos or smoking or both,, you can't tell in any individual claimant whether that disease is due to asbestosis and give them a full value, and for the next person, whether that disease is just due to lung cancer and give them zero value. You just can't tell. Science doesn't allow you to do that.
So what you do is you give a discount to everybody so that the net amount of what you would be paying is the same as if you could tell with certainty which among that group was solely due to asbestosis and which among that group was solely due to tobacco.
Q. In that fashion, even if there were more claims due to tobacco, and in that you've got a whole analysis about whether that's true or not, even if there were, would the approach that the Trust took of discounting the claims of all smokers be an approach designed to recognize the fact that they are going to have more claims?
A. Yes. By taking the discount, they keep the aggregate
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dollars down to the level they would be if they could identify with total accuracy just those people who were sick because of asbestos.
Q. I have gone back to that same question I asked you before. If the Trust wanted to, could they have gone through this whole process of figuring out the percentages, figuring out the dollars, if they wanted to, could they have done it with a sophisticated risk allocation model, if they wanted to?
A. Yes.
Q. Did they decide to do that?
A. No.
Q. They decided to do it a different way?
A. That's correct.
Q. Is this the way that they decided to do it?
A. Yes.
MR. BERNICK: It would be a good time.
THE COURT: You want a break?
MR. BERNICK: Yes.
THE COURT: All right. Take a break.
(Jury leaves the courtroom.)
(Recess.)
(Jury present.)
THE COURT: Be seated. Yes, go ahead, please.
BY MR. BERNICK:
Q. Dr. Dunbar, before we go onto the next time period, I
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want to pick up one other part of your analysis for the Pre-C and Post-C period of time, which is an analysis relating to problems that the Trust had itself in it policies, practices and the plan.
There has been testimony and documents produced in this case that talk about problems that the Trust had with

administering the plan and its decision making. Are you familiar with those?
A. Yes.
Q. Have you reviewed those documents and have you reviewed the related testimony?
A. Yes, I have.
Q. And we're not going to go over all those documents and all that testimony here today. I just want to ask you, have you done some work to determine the impact of those kinds of factors, those kinds of problems on the Manville Share, that is the amount that the Manville Trust had to pay for Manville's own share, have you done that?
A. Yes, I did.
Q. Going back to GZ 20051, which is already in evidence, and directing your attention to page 505246. There's a discussion here about determining the Manville Share, and for the jury's benefit again, remember, is it true that during the Pre-C period of time that Manville Share was applied to the ACF prices?

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A. Yes, it was.
Q. So the price was already set by the ACF, and the way that Manville determined how much to pay was that they used their share?
A. Correct.
Q. What was the estimated Manville Share that the Trust used in estimating the amount that it was going to have to pay?
A. Ten to twenty percent of the gross amount of the claim.
Q. And this is before they ever began to settle anything?
A. Yes.
Q. This was back in April of '88?
A. Yes.
Q. How have you used -- let me ask another question. When it actually came time to settle these Pre-C claims, these right here, was the ten to twenty percent simply always taken, that is whatever the ACF price was, it was ten to twenty percent, or was there some other approach that was used?
A. Initially, the Trust tried to hold to the ten to twenty percent. They would come in to a negotiation with the plaintiffs' attorneys, saying, here's what we feel is fair, but what happened was, the plaintiffs' attorneys would say, Well, no, we actually heard the share is much higher, like thirty or thirty-five percent.
So it became a negotiation, and basically the key variable in the negotiation became this percent number. So

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instead of holding to the ten to twenty percent range, the Trust started with that number and then got negotiated up to a higher number inevitably.
Q. If, as you say, the ACF price, the total ACF price was locked in place, was there any other way that the plaintiff's lawyer, in trying to do better for his client, could increase the price other than to negotiate the Manville Share?
A. At this time the Manville Share is what was negotiated because that was the way that Manville was trying to settle all these claims, was to focus on share.
Q. Showing you GZ 201049. Is this a document that reflects some aspect of one of the negotiations in May of 1988 (Handing.)?
A. Yes, it is.
Q. This is May of 1988, during this Pre-C period of time,

16 right?
17 A. Yes, it is.
18 Q. And it's on the letterhead of the Manville Personal
19 Injury Settlement Trust and re Fred Baron visit.
20 Fred Baron was a very prominent plaintiffs' lawyer?
21 A. A prominent Texas attorney.
22 Q. He had a very large number of claims?
23 A. Very large.
24 Q. The letter is from to Marianna Smith, the executive
25 director of the Trust?
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1 A. Yes.
2 Q. It talks about Gregg being given authority, Gregg Smith's
3 evaluation, the same Gregg Smith we were talking about a
4 little earlier?
5 A. Yes.
6 Q. It says, I have given Gregg the authority to negotiate
7 the Texas cases up to 8,120 699 dollars. Gregg will make
8 every effort to settle the remaining 13 cases for an amount
9 between 18 and 20 percent.
10 Is that the reference to that market share?
11 A. Yes.
12 Q. In my discussions with Fred, he has indicated that he
13 would be looking for something between 25 and 30 percent,
14 which is more than what we want to pay on these cases.
15 Is this kind of typical, the Trust is aiming for that
16 ten or twenty but the lawyers are aiming for more?
17 A. Yes, ten to twenty in the early phases became just a
18 starting point for the negotiations.
19 Q. Now, it turned out that ultimately when resolution was
20 reached with Mr. Baron, this is GZ 201046, is this another
21 memo from Mr. Smith to Marianna Smith, again talking about
22 Baron and Budd, Fred Baron?
23 A. Yes.
24 Q. Does this reflect that by the time things got to be in
25 place, that the final cases settled for 13,225 thousand. That
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1 would be something over 25 percent market share?
2 A. Yes, because 25 percent market share is about 13.19
3 million, and they settled it at 13.2 to 3 million.
4 Q. Is that consistent with the pattern that you saw with
5 regard to these negotiations?
6 A. Yes, it is.
7 Q. Let me ask you something. Did you ever see that the
8 Trust ever did an actual market share analysis, that is they
9 sat down and said with respect to any of these negotiations
10 what really was Manville's portion of the asbestos market so
11 we can negotiate with these guys, did you ever see that?
12 A. No.
13 Q. Did you ever see anything that told the Manville claims
14 people or the Manville executive directors saying, here's what
15 our market share is. We should pay no more and we should tell
16 the plaintiffs' lawyers that's it?
17 A. No, nothing like that.
18 Q. Showing you the deposition of Marianna Smith, the
19 executive director, at page 97 line 4. This again will be
20 played.
21 Certainly, if the Trust officers were following -- if
22 the Trust were following the procedure, the statistical
23 procedure approved by the Board of Trustees, somebody should
24 have done a market share analysis and submitted it for

25 approval, that would support picking one of these market
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1 shares. Correct?
2 Answer: Someone should have, someone may have, I
3 have no recollection.
4 Question: That would have been a reasonable, and
5 responsible, and sound procedure, correct?
6 Answer: Yes.
7 Question: I want you to assume for purposes of my
8 question, Miss Smith, that there is no documentation of such a
9 market share analysis. Would that have been consistent with
10 good practice of a Trust in resolving claims?
11 Answer: If one assumes that there was not any form
12 of statistical analysis, it would not be good practice.
13 Did you ever see such a form of statistical analysis
14 that they actually used?
15 A. No, not by the Trust.
16 Q. Was another problem that the Trust faced during this
17 period of time, that is the Pre-C period of time, that there
18 was not a lot of information that was gathered in order to
19 analyze the claims?
20 A. That's correct. It was consistent with their
21 negotiations strategy that they kind of minimized the amount
22 of information per claim.
23 Q. Showing you GZ 20003. This is already in evidence. Are
24 you familiar with the memo dated October 22, 1992, from Melvin
25 Glass to Bob Clair?
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1 A. Yes.
2 Q. This says that it is correct that we settled the
3 pre-petition cases for less than the court docketed cases that
4 were set for trial.
5 The pre-petition cases, those are the Pre-C cases?
6 A. That is Pre-C, yes.
7 Q. Were settled in groups because of the expediency factor
8 and the files were mostly absent of information that would
9 have allowed them to be evaluated individually. However, this
10 was what we were told to do and we did it.
11 Did you see any other documentation that the Trust
12 had made an arrangement with the plaintiffs' lawyers to pay
13 the Pre-C claims real fast?
14 A. Yes.
15 Q. In fact, is it true that the Pre-C claims, these 15
16 thousand, 12 to 15 thousand claims, were all negotiated during
17 a period of time of roughly May of '88 through November of
18 1988?
19 A. That was the intent. I think about 12 thousand of the 15
20 thousand were negotiated over that time frame.
21 Q. If we take a look during the period of time of the Post-C
22 period, again have you analyzed whether the Trust's own
23 problems and issues affected the negotiation and payment
24 process?
25 A. Yes.
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1 Q. The jury has already seen GZ 20016, which is a
2 presentation of the Trust's financial performance in October
3 of 1988 just before consummation, and they have already seen
4 that the Trust has got a lot of financial problems -- let me
5 get the last page -- so much so that they are considering
6 modification of the plan?

A. Yes.
Q. Voluntary compliance on the part of Manville and the plaintiffs' bar, and even a Trust bankruptcy before it even opened its doors.
Are you familiar with that documentation?
A. Yes, I am.
Q. Did the Trust realize, even before it actually opened its doors for business, that it was going to run out of money?
A. Yes, run out of cash.
Q. There has also been testimony that as a result the Trust, nevertheless, went ahead and decided to open for business and they went around the country asking lawyers not to file claims so quickly.
Are you familiar with that?
A. Yes.
Q. What was the consequence of all that, what happened to the rate of claim filings against the Trust during the Post-C period of time?
A. The filing rate went up. What happened was the attorneys

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who were being told about the problems of the Trust put 2 and 2 together and came to the realization that the Trust was going to run out of money.
So that would indeed -- if they filed their claims late, that would leave their clients kind of high and dry. So what happened was, in order to get their claims paid first, they sped up the filing rate, and then they figured out that if they hadn't gotten a response by the Trust in 120 days, which was very difficult for the Trust to do because they were flooded with new claims, they could name the Manville Trust on an existing lawsuit, just add the name of the Manville Trust as a defendant on an existing asbestos lawsuit, and that would force the Trust to come to them to settle, otherwise the Trust had to go to try their case in court and be -- and risk a major judgment against it.
Q. As a result of that, what happened to the trial docket, what happened to the docketed cases that were going to court?
A. They increased. They increased a lot over this time period. And when you have trials, you have to send attorneys in to try to defend yourself and that -- and the Trust wasn't set up as a litigation vehicle.
It was not set up to litigate. It always preferred settlement, so it didn't have the staffing and it didn't have the philosophy that that was needed in order to try to combat these cases at trial.

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To do so would have taken a lot of resources. It would have cost them much more to try these cases, and that would have left less money available for the claimants, who they viewed as their true beneficiaries.
Q. Is it true that a time came aways into the Post-C period of time when the whole process was stopped -- and we don't want to get into details of how that happened -- just the process was stopped?
A. Yes.
Q. At that time, is it true that the Trust was spending almost a million dollars a week on attorney's fees to defend all those cases?
A. Yes, that's true.
Q. Now, have you taken a look to see whether this flood of claims and the pressure that it put on the Trust led to the

Trust spending more money per claim, that is, it's been ratcheted up?
A. Yes, I have.
Q. Turning back to GZ 200033, which is the Glass memo, does this talk again about this period of time?
A. Yes, it does.
Q. It says that the court docketed cases were another matter. They were evaluated individually. However, again, there were times when we did not have all the information to be comfortable with the number. But the biggest problem with
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these cases was the lack of notice of the trial date.
Many times we received call from defense counsel advising us that the trial was starting that day. Moreover, it was the plaintiffs' counsel who informed us that the trial was imminent. Therefore, because of the courthouse steps and other related factors the trial docketed cases usually were settled for a premium amount. Premium amount being what?
A. To give you some numbers on this from the standpoint of planning. When, back in the, say, 1987 time period, when the Trust was trying to figure out the dollars it had versus what it was going to pay, about 22 thousand dollars per case was what they were assuming, and that was based on what the average had been that Manville itself had settled for before it had gone into bankruptcy.
By this time they were settling the cases for an average of 47 thousand dollars, which, when you roll that into the Pre-C cases, meant that over this entire time period, both the Pre-C and the Post-C, the average was actually 42 thousand dollars.
That was how much they had increased from what they thought the cases were going to be settled for, from 22 to 42.
Q. There's a reference here to the Cimino settlements. Was that a class action settlement in Texas?
A. Yes.
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Q. Did Mr. Smith testify about that as well?
A. Yes.
Q. Showing you page 77 of Mr. Smith's deposition. It says, Did Marianna Smith settle the Texas class -- she's again the executive director?
A. Yes, she actually -- rather than having the claims negotiators settle that case, claims negotiators settled most of the cases, Marianna Smith herself did the negotiation on the Texas class action, the Cimino case.
Q. Mr. Smith testifies as follows on page 78:
Do you recall how much more she settled the claims for than the amount recommended by the people who did the individual evaluation?
Answer: Not exactly. Not much, no.
Can you give me an order of magnitude?
Answer: Some number of millions of dollars. I would suggest thirty or forty million. Thirty or forty million, I don't know.
More than the recommended amount?
Answer: Forty is probably on the high side. Probably somewhere around 30, I would guess.
Are you familiar with her testimony?
A. Yes.
Q. Did you determine how much the Trust ended up paying

during the Pre-C and Post-C period of time as a premium over
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the originally estimated market share of ten to twenty
percent?
A. Yes, I did.
(Continued next page)
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page 5766
EXAMINATION CONTINUES
BY MR. BERNICK:
Q. And is this reflected in DEM-012140?
A. Yes. Actually the market share that I used was at the
high side of that range, I used twenty percent, so this
says -- this tells us that if they had been able to adhere to
the twenty percent market share, then the amount they would
have paid is shown by the yellow orange wedge and the amount
over that they paid shown by the red wedge.
Q. Does this amount have anything to do with anything other
than just the negotiation and claims administration process?
A. No. It doesn't have anything else to do with that. It
is just the summation that the Trust found itself in during
this time period.
Q. Did this require, these numbers, did they require any
elaborate modeling? Where did you get the information for it?
A. These numbers I got off of the claims analysis
summaries. We were able to find the market share numbers off
of those for the post-C periods and then in the preC periods,
we had access to the actual settlement files that the Trust
had for about six thousand of the claimants and in those files
we were able to find out the negotiated share. So I just took
the average share from those files and from the CAS form and
then compared that to what it would be if it was twenty
percent.
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Q. Showing you DEM-012141. Let's try then to make a
transition from the pre-TDP period of time. That is, the
transition from here to here.
Are you familiar with the fact, Doctor Dunbar, that
the claims that are being made by the Trust in this case focus
on monies that were paid out during the TDP period of time

from 1995 to the present time?
A. That's my understanding.
Q. Have you looked to see if impact of all of what we have discussed about the tobacco discount, have you looked to see what the impact of that was on pricing during the TDP period of time?
A. Yes, I did.
Q. Okay. Let's just draw a very similarity to the one we have here.
THE COURT: When you get a chance, put numbers on those two charts, please.
MR. BERNICK: Okay. We have a total of one, two, three, four. This will be number four. Dunbar four.
Q. Would it be fair to say that during the pre-TDP period of time, the result of all of the monies that had been paid out for the Manville share during this period of time was to establish kind of a going price, a historical price for settling claims?
A. Yes. It's historical averages, historical prices, yes.

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Q. Is it also fair to say that in putting together the TDP, jury has heard testimony about the TDP having scheduled values. That is, for a given claim, or type of claim, the price or the dollars that were associated with that.
A. Yes, that's the matrix value.
Q. Okay. Have you looked to see whether in the process of negotiating the TDP, whether the historical prices were used to determine the scheduled prices?
A. Yes, I did.
Q. You have told us from your prior testimony that the historical prices excluded tobacco. It was taken off the top.
A. Yes.
Q. Did you look to see whether in putting together the scheduled values that the historical prices were increased in order to pick up tobacco?
A. I looked at that, yes.
Q. Okay. Did you find historical documented evidence on whether the historical prices pre-TDP were used to set the scheduled values? Did you find them?
A. Yes.
Q. The TDP negotiations, did they take place over a period of time?
A. Yes. They took place from about 1990 through the end of 1994. Or through 1994.

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Q. Have you got a series of documents here that span from 1990 up through 1993 and into 1994 that talk about the negotiation process in setting values?
A. Yes, sir.
Q. During this period of time, is it also fair, that the proposed TDP also changed itself?
A. Yes, it did.
Q. Okay. Showing you GZ-200365, a memo dated October 25, 1990, from various people, including those claims people, to Mark Peterson. He was an outside consultant to the Trust?
A. He was an outside consultant, yes.
Q. Okay. Does this relate to comments and suggestions and value ranges for claims categories?
A. Yes.
Q. Is this one of these documents that's associated with the

process of developing the new deal?
A. Yes.
Q. It says here, number one, our values were derived from historical averages and, where possible, from the profile project in beginnings with the historical averages.
Is this the kind of documented evidence that you found regarding the use of historical pricing?
A. Yes. This shows the process which the Manville trust was going through in order to determine WHAT would eventually --- became the matrix involved the use of the historical averages
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of the settlements that they had been paying in the preC and the post-C time period.
Q. The TDP distribution process, this is GZ-201216, was there an original or earlier TDP proposal?
A. Yes, there was, around the 1990, 1991 time frame.
Q. Turning to page three. This says, for each type -- claim valuation -- claim valuation by category. For each type of disease, the Trust, the selected counsel for the beneficiaries and the special advisor to the Trust have together established a midpoint and maximum value for claims against the Trust based upon experienced settlement values for claims for that disease.
Again, is that a very similar reference in the same concept?
A. Yes.
Q. Okay. In fact, the values that were discussed here talk about anticipated mid-points of one hundred twenty thousand for the smoker, seventy thousand for the non-smoker. Are those very similar to what was used in the pre-TDP period of time?
A. In the first TDP, yes. In the latter TDP they were different.
Q. We will talk about how that is true. GZ-201171, is this another document now in 1993 in connection with the second TDP to Pat Houser, the executive director, again talking about the
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matrix which was going to be the scheduled values?
A. Yes.
Q. Page two says, there will be a minimum and maximum state average so that outlier states will be brought within the normal average range. In fact, by taking the midpoint between state and national average, all states will be brought closer to the national average.
Again, is this a statement regarding the use of historical values in developing new values?
A. Yes. This is showing that they are converging on the eventual matrix values by using these averages.
Q. When push finally came to shove and the new values were put together, were those new values in fact, the new values for the TDP, the scheduled values, were they in fact based upon the historical values?
A. Yes.
Q. Were there a couple of adjustments that were made?
A. Yes.
Q. What were the adjustments that were made?
A. The main one was that the pleural claims were reduced in value. I believe the historical average was on the order of nineteen thousand, and the matrix value in the final TDP became twelve thousand. The stated reason for that is that over this time period, various state jurisdictions began

ruling against plaintiffs on pleural claims, claiming that
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because the claimant was really not impaired they couldn't collect money. So they felt those values declined in value.
Also, the mesothelioma -- the top bracket of mesothelioma matrix value was decreased.
Q. There has been discussion about Rabinovitz who participated in the formulation of the model in this case. Did she testify in her deposition at page 33, the same way, that is, question, and that the claims values -- I should say the scheduled values for the TDP were based upon those settlement values, and to the extent that they were litigated, those litigated values?
Answer: Yes.
Again, is that consistent with exactly the same point?
A. Yes.
Q. There has been testimony from the only trustee who has appeared here, Mr. Macchiarola, testified as follows, at page 1339.
Isn't it true that in order to negotiate the TDP prices to insure that they would be fair, the Trust actually went back to the -- the claimants themselves went back to take a look at what the historical values had been, in order to assure that the new TDP values were consistent with what had been paid by the Trust in the pre-TDP period? Isn't that true?
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Answer: That's correct.
Further on: So basically, the idea was, in coming up with that schedule of values, that everyone went back to see what the Trust had paid out, what they had done pre-TDP for whatever reason, they took the dollars that were set as the dollars that had been paid out pre-TDP and they set the new dollars based upon history?
Answer: Correct.
Again, is that consistent with what you have discussed?
A. Yes.
Q. Have you determined whether in fact, in fact, the values, settlement values pre-TDP line up with the expected values post-TDP?
A. Yes.
Q. Have you done that both in the aggregate, that is, with respect to all money that was paid out pre- and then expected to be paid post-TDP and have you also done it by certain diseases?
A. Yes.
Q. Let's begin with the aggregate. That is, whether the amount of money that was set to be paid on the TDP was lined up to be and the schedule was adopted so it would exactly match the amount of money that had been paid out historically.
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First of all, was there documentation submitted in connection with the approval process for the TDP which shows this?
A. Yes.
Q. Showing you GZ-201214. In going to the liabilities part, it says, there is a line here saying: Average liquidated

value per claim, with class action settlement, that's the new deal?
A. Yes.
Q. Forty-two thousand eight hundred twenty. Without the class action settlement, the same number?
A. Yes.
Q. What does that tell us?
A. That number is very close to the average value for the pre-TDP. The average value pre-TDP was forty-two thousand two hundred eighty dollars. So this shows that they were keeping in aggregate the average values close together in the planning process.
Q. Now, back in a different era of this case, Mr. Austern was on the stand. He is the former general counsel of the Trust, now he's running the Trust company, whatever it is. We had a long discussion back and forth about how much money was actually paid out on average pre-TDP and the average liquidated value under the TDP. We went back and forth on whether it was the tort system or historical values.

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Ultimately we filled out what is Austern number two and it shows under the pre-TDP period of time, average value, forty-two thousand. Under the actual TDP, average liquidated value, forty-two thousand.

Do these numbers all line up?

A. Yes.
Q. What do they tell us about whether the before picture and after picture, that is, the pre-TDP and post-TDP, were designed to line up and be the same?
A. This shows that the -- they had planned the TDP to have the same overall average value as had been their historical experience.
Q. This was his testimony, at page 2124.

Question: Is it correct to say that the average cost of resolution pre-TDP is on average the same as the average scheduled value under the TDP?

Answer: Yes, it is the same scheduled -- the average of the scheduled values is the same.

If that is true, what does that tell us about whether the scheduled values were increased in order to start to pay for tobacco? What does that tell us?

A. That they were not. The historical values excluded shared causation, which was the tobacco portion of the damages, and the fact that the TDP values are about the same as the pre-TDP values, means the tobacco was also excluded.

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Q. I asked him that very same question. Page 2206, line 17 in this trial.

Question: Isn't it a fact, Mr. Austern, that under the TDP there was no change in the net aggregate amount that the Trust was paying?

Answer: There was no change in the net aggregate amount.

Is that consistent or inconsistent with what you found?

A. That's consistent.
Q. Does DEM-012142 reflect the actual numbers?
A. Yes.
Q. What does that say about the Manville share that was actually paid by the Trust pre-TDP and the Manville share that was scheduled for payment by the Trust post-TDP?

16 A. They were virtually the same.
17 Q. Did you do the same analysis by disease category for lung
18 cancer, and asbestosis and BID?
19 A. Yes.
20 Q. Okay. How did you go about doing that?
21 A. What we did was we computed that the average lung cancer
22 claim had been pre-TDP, both the smokers and non-smokers, and
23 then we computed what the anticipated average would be with
24 the TDP at the time that it was being negotiated, taking into
25 account how the claimants would likely distribute themselves
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1 among category six, category five and some lung cancer
2 claimants would actually end up in category zero with no
3 payment at all.
4 Q. Okay. What did you determine? Was this a little bit
5 more complicated an analysis?
6 A. Somewhat.
7 Q. Okay. Do we have DEM-012143? Does this show how the
8 overall averages preTDP and projected TDP actually would line
9 up for lung cancer?
10 A. Yes, it does.
11 Q. Now, we know that pre-TDP smokers were paid on average
12 less than non-smokers.
13 A. Correct.
14 Q. Was the same approach, there has been a lot of testimony
15 about the pricing of these categories under the TDP. Was the
16 same approach taken under the TDP or not?
17 A. The same approach was taken.
18 Q. Okay. When it came to actually pricing, was it necessary
19 for the difference between category one and category two under
20 the TDP, is that designed to somehow capture the whole
21 difference between smokers and non-smokers so it's to avoid
22 paying for the tobacco share or is it something that is
23 different?
24 A. It is different.
25 Q. Tell the jury how it is different.
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page 5778
1 A. Category -- instead -- remember earlier in the first TDP
2 what they had said was that a category one was going to be one
3 hundred twenty thousand and a category two was going to be
4 seventy thousand. In the course of the negotiation, the one
5 hundred twenty thousand actually became ninety thousand.
6 The reason for that was that they let into category
7 one, in addition to the non-smokers who had lung cancer, a
8 group of people who would have smoked but would have had other
9 additional evidence of an asbestos related disease and so
10 those folks are ones who -- though they nonetheless smoked,
11 you could say with some confidence that at least a large part
12 of their disease was due to the asbestos exposure.
13 Letting those -- that fraction of non-smokers into
14 the top category along with -- I'm sorry. Letting that
15 fraction of smokers into that category along with the
16 non-smokers caused that one hundred twenty thousand to drop to
17 ninety thousand because we were letting a lot more people in.
18 The category two then became reserved for all the
19 rest of the people who had fifteen years or more of exposure.
20 So that would be only smokers with fifteen years or more of
21 exposure and then the rest of the lung cancers dropped out.
22 They became zeros. Those would always be smokers also.
23 Q. Were category one and category two prices on the TDP
24 designed to actually raise scheduled values beyond what they

had been and pick up tobacco? Were they designed to do that?
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A. No.
Q. Did the Manville share, that is, the portion that Manville was said to be Manville's, did that remain the same or was it different as you went to the TDP?
A. In terms of the scheduled values, it was the same.
Q. When it came to shared causation, the tobacco portion, even under the TDP, was that claim excluded from the amounts that were scheduled for the Trust to pay?
A. Yes, on average.
Q. Now, there is one big difference, isn't there, between the prices that were pre-TDP and the payout, the payout pre-TDP and payouts under TDP?
A. Yes.
Q. What is that difference?
A. They are paying out ten percent.
Q. They are paying out ten percent.
Let's do the same chart here. Modified. DEM-012148.
Does this graphically illustrate to the jury, I really wish we could do better on the graphics.
Does this illustrate to the jury the ten percent point?
A. Yes.
Q. The ten percent we have the same Manville share?
A. Twenty-seven percent over all.
Q. Twenty-seven percent. Is this the scheduled value under
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the TDP?
A. Yes.
Q. Does it correspond to that right bar over there?
A. Yes, it does.
Q. The amount that actually is paid by Manville is ten percent?
A. Yes.
Q. Which would mean that the percent of Manville -- the percent of the total value, the percent of the total value actually paid by Manville is what percent?
A. Three percent, rounded.
Q. Does this remain true for not only lung cancer but also BID and DBID?
A. Yes.
Q. Now, the ten percent is only a portion of the Manville share, is that what you said?
A. Yes.
Q. Okay. I want to read or show to the jury -- actually, there are two that I had here.
A request for admission. This is request for admission number 86. It is GZ-201246.
It says: Request, admit with respect to all claims resolved pursuant to the TDP the Trust has not yet paid out all of Manville's liability.
The response is this: Admitted that with respect to
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claims resolved pursuant to the TDP, the Trust's ten percent payments to each claimant does not exhaust Manville's liability as assumed by the Trust to each or any claimant.
Is that consistent or inconsistent with your own understanding?
A. That would be consistent.

(Continued on next page.)

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Q. Showing you the testimony of Mr. Macchiarola, who testified as the Trustee, at page 1357, line 14.
Isn't it a fact that Manville's liability -- Manville's share, forget about tobacco -- Manville's share, Manville's liability, what the Trust is supposed to be paying, far exceeds the 10 percent dollars that are being paid out today and have been paid out in the past, true or not?
Answer: That's true.
Again, is that consistent with your own views as you formed them here?
A. Yes.
Q. That amount that's paid, does that include any tobacco shared causation dollars?
A. No.
Q. Where are the tobacco share causation dollars, as defined by the Trust's own procedures?
A. That's the part that's not paid. The shared causation is taken out of the gross value and is not paid by Manville.
Q. The amount that's actually paid, is that Manville liability, is it tobacco liability, is it Manville Share, tobacco share, or somebody else's share?
A. The amount paid is supposed to be Manville only liability, both with respect to asbestos and noted causes of the diseases.

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Q. Now, even though -- is that your opinion based upon all that you have reviewed, the documents, the prices, the analysis, the history?
A. Yes, it is.
Q. Let talk about what the Trust is claiming in this case. The Trust is saying that of the amount that its actually paid, a part is due to us and recoverable from us. Have you indicated that here on your chart?
A. Yes.
Q. That is of the amount they have paid out, we're responsible for a slice. Is that inconsistent or consistent with how the Trust's prices and values have been determined and paid?
A. I find that inconsistent because the Trust hasn't actually paid out for tobacco dollars.

Q. As the Trust is making its claim here, given that claim, whose money, whose liability, whose share is the Trust saying that we should pay?
A. Any amount that comes out of the Manville Share, as they have already settled it, would be Manville's liability.
Q. I want to show you DEM 012152 to kind of maybe do a little bit of a recap here on the history and how it works out.
I know we have gone through pies and other things, and I have a large version of it here.

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During the ACF period of time -- you may want to stand down here a for a second, Dr. Dunbar, so you can point this out and do the talking instead of me.
During the ACF period of time, before the Trust, who was it that was paying the claims, was it Manville or was it the other asbestos companies?
A. These are the thirty to forty asbestos companies that were in the asbestos claims facility.
Q. Now, when the ACF agreed to pay claims, did they or did they not exclude tobacco?
A. They excluded tobacco.
Q. Did they or did they not exclude Manville's share of the asbestos liability?
A. They excluded all the non-ACF codefendants, and that included Manville. Manville was not part of the ACF.
Q. Now, you told us that the ACF prices were carried over to the Pre-C settlement. Would that be roughly like here?
A. Yes.
Q. And that as a consequence, the tobacco portion, again, was excluded from the Pre-C settlements; would that be fair?
A. Yes.
Q. What about the liability of the other asbestos companies, did Manville have to pay the liability of the other asbestos companies?
A. No. That was not part of their charge. They tried not

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to pay that.
Q. So the idea was, in the Pre-C period of time, is that nobody pays for tobacco, and now the other piece of the asbestos liability gets paid, is that correct?
A. Yes.
Q. Let's go to the Post-C period of time. This is now individual evaluation, the form that you showed us?
A. Yes.
Q. Again, was or was not tobacco excluded from the Manville payment?
A. Manville consciously excluded tobacco in the shares causation, that's correct.
Q. What about the liability of other asbestos manufacturers, was that included or excluded from the Manville payments?
A. That was excluded in the Manville Share.
Q. Now, in going from Post-C to TDP, I think you told us on that chart right there that the values, by design, were to remain the same. Those are the scheduled values?
A. On average.
Q. Again, does that mean that tobacco is included or excluded from the payment under the TDP?
A. Tobacco is excluded from the average in the TDP.
Q. And actually I probably drew the wrong line. It should have been scheduled values down here. Is that correct?

25 A. Yes.
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1 Q. They exclude both tobacco and other asbestos?
2 A. Yes.
3 Q. But the amount that Manville is now paying has been
4 reduced ten percent?
5 A. Correct.
6 Q. Is that a fair representation of the sequence that we
7 followed here?
8 A. Very fair.
9 Q. Thank you. I will put this one in place and ask you one
10 more line of examination and I'm done.
11 For the record, I'm not sure I said it, DEM 011252.
12 Did you also take a look in the same fashion -- you
13 told us during the Pre and Post-C period of time that
14 Manville, the Trust, ended up paying a premium amount by
15 reason of some problems that the Trust had. Do you recall
16 that?
17 A. Yes.
18 Q. Do we have a similar problem with respect to the amounts
19 that were paid by the Trust during the TDP?
20 A. Well, you have the scheduled amounts, because they were
21 based on these historical averages. Then the scheduled
22 amounts also include those -- the scheduled amounts also
23 include that meaning.
24 Q. Were there other problems that the Trust had during the
25 TDP period of time?
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1 A. Yes, there were.
2 Q. What were those problems with?
3 A. What happened was, in the negotiations, in order to
4 reduce the cost to the Trust of administering the claims and
5 getting out of the tort system, they created a procedure where
6 data would be sent to the Trust from, again, the plaintiffs'
7 attorneys, and the Trust would look at it and classify that
8 claimant as either having enough data and falling into a
9 particular point on the matrix, or not, and what happened was
10 the criteria that were used allowed a lot of claims to come in
11 from people who were unimpaired or didn't have actually the
12 proper support for the diseases that they were getting paid
13 for.
14 So the amount of claims went way up, much
15 higher -- to a much higher number than they had anticipated.
16 Q. Did the Trust conduct an audit in order to find out what
17 the cause of the problem was?
18 A. Yes, they did.
19 Q. What did they find as a result of the audit?
20 A. They found that there were probably overpayments in just
21 about every category, but they found that the BID category was
22 the one which had the worst problem.
23 In the course of an audit, which was arguably very
24 pro-plaintiff, they ended up finding that in many time periods
25 that over fifty percent of the claims failed the audit.
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1 Q. Is there extensive documentation of this, that we're not
2 going to go through again today?
3 A. Yes.
4 Q. Did even Patricia Houser, the executive director of the
5 Trust, come to the conclusion, in her own review of the
6 situation, that the TDP was not being followed and the claims

that were being filed were not entitled to compensation, did she come to that conclusion?
A. Yes.
Q. Is the same kind of conclusion expressed in the correspondence, including correspondence even from Mr. Austern, who testified here?
A. Yes, that's correct.
Q. Was the position of the Trust in all of that correspondence and all those negotiations for years and years that basically what was happening was that the criteria for these diseases were not actually being followed and that people were filing claims that really were not proper claims?
A. Initially, the criteria were not being followed. They tightened up on the criteria. They still had major problems in that the criteria were not being followed, and they were getting a lot of claims where there just wasn't the support for the disease and they had to pay the claims anyway, as per the negotiated settlement of the TDP.

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Q. Showing you Mr. Macchiarola's own testimony here in this court, page 1345. I asked him:
You can't tell us whether any or what portion of the TDP claims that were paid were for people that actually had lung cancer, can you?
Answer: That's correct.
Question: You can't tell us what portion actually had asbestosis, correct?
Answer: I believe that is correct.
Question: You can't tell us which ones actually had bilateral interstitial disease, correct?
Answer: That is correct.
Page 1346.
You cannot tell us which ones of the claimants, or what group of the claimants, in fact, even satisfied the TDP's lesser standards, can you?
Answer: Same answer.
Again, is that consistent with what you have read in these documents?
A. Yes.
Q. Have you done your own review of some of the underlying facts?
A. Yes.
Q. Have you done your own analysis of the quantitative impact of those facts?

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A. Yes.
Q. Showing you DEM 012153. Does this reflect the results of the audit with respect to some of the highest volume doctors?
A. Yes. These were doctors that were preferred doctors by some of the largest plaintiffs' law firms, and these doctors would be submitting hundreds of analyses for x-rays and analyses of x-rays in the claim files, and when the Trust had two people reread the x-rays, if one of those agreed with one of these doctors it passed the audit, but if both of them disagreed with these doctors then it failed the audit, and this shows the result for some of these high volume doctors.
Q. Did you prepare your own chart about the financial impact of this problem?
A. Yes.
Q. Showing you DEM 012154. Again I apologize for the

16 quality. We were going to get the TV back in here this
17 morning but we didn't have time to set it up.
18 Does this reflect the results of your analysis of
19 some of the numbers?
20 A. Yes. This shows the actual payments for asbestosis made
21 in the TDP, and what I did was I deducted out over this time
22 period the percentage of the claims made by these doctors that
23 failed the audit, just those ten doctors.
24 I didn't even look at other doctors that failed the
25 audit. You see it's about a hundred million dollar issue.
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1 Q. Does this difference have anything to do with tobacco?
2 A. No.
3 Q. Did the extra amounts that were paid by the Trust as a
4 result of its own problems during the Pre-C and Post-C periods
5 of time, did they have anything to do with tobacco?
6 A. No, they did not.
7 Q. Did some of the problems that the Trust had even affect
8 the projected mix of claims between these different
9 categories?
10 A. Yes. That's correct.
11 Q. Let me be clear. When you developed this number, there
12 was a projected mix of claims, right?
13 A. Right. For those that were not marked down to category
14 0, the projection initially was going to be two-thirds in the
15 first category, category 1, and then one-third in category 2.
16 So that was 67 percent versus 33 percent. That was
17 marked up a little bit by 1994. But basically that's the
18 range that we're talking about.
19 Q. And as it actually evolved because of some of the
20 problems that the Trust had with its claims process, did it
21 affect that mix?
22 A. That mix is 85 percent in category 1 and 15 percent in
23 category 2.
24 Q. Setting aside the problems that the Trust actually had
25 with the criteria that it created, that is this problem with
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1 the TDP criteria and this leakage that you've referred to, in
2 your own experience, you have worked with a lot of different
3 claims facilities, have you not?
4 A. Yes.
5 Q. The procedures that the Trust adopted in order to avoid
6 paying for any share, the Manville Share that is, the
7 procedures that it adopted Pre-C, Post-C and TDP to make
8 paying values and payments that didn't require that the Trust
9 pay for other asbestos, and it didn't require that the Trust
10 pay for tobacco, were those good procedures, that is, was the
11 Trust diligent in avoiding paying for tobacco?
12 A. I think the Trust did try to avoid paying for tobacco in
13 the Pre-C and the Post-C period. They used the ACF deduction
14 in the Pre-C, they put in their own deduction in the Post-C,
15 and then that carried through to the matrix values in the
16 TDP.
17 Q. Even when it came to determining how to carry forward the
18 aggregate values, did the Trust do a pretty decent job in
19 figuring out how to carry forward the aggregate values,
20 indeed, the category values?
21 A. Yes.
22 Q. I want to get back to the question that I have back here
23 about, we know that from your testimony, before the TDP --
24 it's over here too -- I can point either way -- there was this

effort to avoid paying for tobacco.
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Are you aware, we've asked witnesses on the stand whether at any point in time prior to this lawsuit being filed, did anybody at the Trust or outside the Trust take the position that the Trust was paying for tobacco now?
We've asked everybody that question and I'll represent to you that nobody has said, yes, before the lawsuit was filed, we said we were paying for tobacco.
Have you seen any evidence whatsoever that in the development of the TDP, in the effectuation of the TDP, that there was somehow an effort to increase those scheduled values so that the Trust would start to pay for tobacco liability, have you ever seen anything like that?
A. I have not seen anything like that.
MR. BERNICK: That's all I have, your Honor.
THE COURT: Do you want a few minutes before you start in?
MR. STENGEL: A couple of minutes would be helpful, your Honor.
THE COURT: Take a break, please.
(Jury leaves the courtroom.)
MR. BERNICK: I have a question for the court, if you have a moment?
THE COURT: Yes. You may step down.
(Witness leaves the stand.)
MR. BERNICK: Your Honor, you will notice that I did
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not make use of the dollar figure of the Trust's claim. I had a graphic prepared to indicate where the Trust's dollar claim fit into the picture and I couldn't do it because I still don't have that dollar figure.
I'm not quite sure what to do, except that I suppose it will mean that we're not really -- I'm going to have to reserve to call Mr. Dunbar back. I really don't want to do that.
THE COURT: No. You can have him do it outside the presence of the jury and we will put it in later.
MR. BERNICK: All right.
(Recess.)
(Jury present.)
THE COURT: Yes.
CROSS-EXAMINATION
BY MR. STENGEL:
Q. Good afternoon, Dr. Dunbar. How are you?
Dr. Dunbar, I'm going to -- I think timing is important here -- I am going to create a different time-line which I will put on this board, and we will call this Plaintiffs' Dunbar 1.
I don't claim any great artistic ability, but we'll see what we can do.
The Trust history starts basically in 1988, correct?
A. Well, the Trust was staffed in '87, but if you want to
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start in '88, fine.
Q. Let's put 2000 over there, and you talked basically about three time periods this morning, correct, Pre-C -- what dates did you attach to the Pre-C period?
A. Pre-C period, in terms of negotiations are --
JUROR: Excuse me. We can't hear you.

Q. I'd ask you to speak up, sir.
Dr. Dunbar, you probably can't see it?
A. It's all right.
MR. STENGEL: Everybody on the jury see that?
Q. Dr. Dunbar, can you see the board?
A. I can, thank you.
Q. All right. I would ask you what dates you attached to the Pre-C period?
A. Pre-C period is basically 1988. Negotiations occurred, most of the negotiations occurred between May and November of 1988.
Q. So this, in your world view, is the Pre-C period?
A. Yes.
Q. How about Post-C?
A. Post-C goes up to about middle of '91, around that point --
Q. Middle of 1990, perhaps?
A. 1990, yes.
Q. Then you have a period of years where there were

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negotiations of what eventually became the TDP, correct?
A. Yes.
Q. The TDP was actually implemented in 1995?
A. Early '95, yes.
Q. Now, in the period 1990 to 1995, it's not like nothing was happening, though, correct?
Although no claims were being paid, there were extensive negotiations over the TDP, correct?
A. Yes.
Q. And there were at least two very different versions of the TDP, correct?
A. There were two different versions, yes.
Q. The first one was negotiated sometime in '90, '91?
A. Yes.
Q. That's the first TDP period. The second one basically occupies the remainder of the period to '95?
A. Well, since -- basically it starts in '95, but it was negotiated, again, say, in the '93 time period.
Q. So we have negotiation for the second TDP.
Then from 1995 on, we have had the payments that are at issue in this case, right?
A. Correct.
Q. Now, in the rest of the asbestos world, things were happening, correct?
A. Yes.

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Q. All along this period, you had active litigation involving other manufacturers?
A. More or less, yes.
Q. And you had a sequence of asbestos manufacturers going into bankruptcy, just like Manville had?
A. Yes.
Q. And we'll call that the court system?
A. Yes.
Q. As far as it relates to this.
And you also obviously had changes in price levels during this time, correct, this 12-year period?
A. That's not necessarily true. I can explain, if you want. If you're talking about average prices aggregated by particular disease, that's not necessarily happening.
Q. I'm sorry, your sophistication is beyond mine. I was

16 just asking on a simple basis whether the consumer price index
17 had gone up over that 12-year period.
18 A. The CPI has, yes.
19 Q. So you've got some amount of inflation going on at the
20 same time.
21 Now, you talked about these various periods in fairly
22 summary form this morning on direct, and because I want the
23 jury to understand exactly how you did some of these
24 calculations, we will revisit these in some greater detail.
25 My next question is, I think you gave us this number
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1 earlier, but how many claims were settled in the Pre-C
2 period?
3 A. It depends on when you're talking about. But if you said
4 15 thousand or thereabouts, you'd be pretty close.
5 Q. Fifteen thousand here, and how many Post-C?
6 A. Another twelve, say.
7 Q. Okay. You know that in terms of the TDP, it's a 300
8 thousand plus number?
9 A. Yes.
10 Q. And I don't represent that that's proportional, but
11 obviously a lot more has happened by way of settlement since
12 the TDP was put in place, correct?
13 A. If by a lot more you mean claims volume, yes, that's
14 correct.
15 Q. A lot more claims had been settled.
16 Now, the next thing I want to point the jury to, and
17 we'll use these numbers as we go through the day, is you
18 talked about two calculations, you talked about -- actually
19 three, I correct myself -- you talked about the market share
20 premium?
21 A. Yes.
22 Q. And to calculate that, you used a group of Pre-C claims,
23 correct?
24 A. Both Pre-C and Post-C.
25 Q. How many claims did you use to do the calculation?
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1 A. Well, Pre-C, I think there are six thousand claims in the
2 database, and we had information on about 3000 other. Post-C,
3 several hundred.
4 Q. So we've got 3000 Pre-C claims that you base your
5 analysis on -- and I will refresh your recollection, I think
6 on the Post-C its 591, correct?
7 A. That sounds about right.
8 Q. And the 591 are the ones you used to do the initial
9 calculation of your smoking discount, correct?
10 A. Yes.
11 Q. So we have some relationships laid out, just so there is
12 no confusion, in the Pre-C period, you saw some documents that
13 talked about not having a lot of information for Pre-C
14 settlements?
15 A. That's correct.
16 Q. Now, as a matter of fact, I think you even testified to
17 this, Mr. Smith and other claims officers at the Trust had
18 worked at the ACF prior to coming to the Manville Trust,
19 correct?
20 A. That's correct.
21 Q. And as a matter of fact, they had settled a substantial
22 number of these very same claims for the ACF, hadn't they?
23 A. I'm not sure that's correct.
24 Q. The ACF had already settled a large number of the Pre-C

claims?
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A. The ACF has settled a large number of the Pre-C claims. What I might dispute is whether Mr. Smith himself had settled a large number of the Manville claims.
Q. All right. And you've told us that Pre-C was characterized by group settlements where a law firm would sit down with someone from the Trust and negotiate a deal?
A. Yes.
Q. But they were negotiated, right, they would sit down, they would have a list of cases, they would talk about the cases, go to each case and the money to the group?
MR. BERNICK: Objection to the form of the question. It's really a compound question.
THE COURT: If you know. If you don't know, say so.
A. They were negotiated that way, yes.
Q. There was somebody on each side of the table trying to do the best they could for their client or, in the case of Manville, the Trust?
A. That's a more difficult question to answer. I would definitely say the plaintiff's attorney is trying to do the best the plaintiff attorney can for the plaintiff's attorneys clients.
The Manville Trust people, it's not clear who the Manville Trust thinks is their client, whether it's the future claimants, the current claimants. What it is, is not quite clear. I kind of disagree with that.
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Q. So you think they were burdened by their fiduciary obligations?
A. The Trust was set up with a set of objectives, and it had a view as to what the beneficiaries were that did -- that in fact did burden them, and that other Trusts since then have been able to resolve in a better way for the future claimants.
Q. Let's turn to the Post-C period. This was, as you told the jury this morning, an era of individual negotiations?
A. Yes.
Q. So each case was negotiated between the Trust and the claimant or the claimant's attorney?
A. Yes, it was.
Q. And then we get to 1990, and payments in claim processing stopped?
A. Yes.
Q. And there are discussions around the first TDP, negotiations?
A. That's right.
Q. And the participants in that negotiation are lawyers for the Trust?
A. Yes.
Q. And lawyers for co-defendant manufacturers and distributors?
A. Yes.
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Q. And a futures representative?
A. Yes.
Q. And lots and lots of different plaintiffs' lawyers?
A. Well, there is something called the SEB, which had three or four or five plaintiffs' attorneys; there was a representative for that group, and then at various negotiating

sessions other attorneys on an ad hoc basis would come in and out, that were plaintiffs' attorneys.
Q. I don't think we need to bother the jury with the details, but the first TDP with its level 1 and level 2, you're familiar with all that, aren't you?
A. I remember much of it.
Q. It was a fairly complex structure?
A. Yes.
Q. And it was a very different structure than the Post-C or, indeed, the Pre-C periods had been in terms of how the settlement process was structured?
A. That's correct.
Q. But for reasons we won't go into here, the first TDP was unsuccessful, correct?
A. That puts kind of a spin on it.
Q. It was never implemented?
A. It was never implemented, I think is more correct.
Q. Is that fair?
A. Yes.

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Q. Then we have a second TDP?
A. Yes.
Q. That second TDP was, again, the product of negotiations among all these interested groups?
A. Yes.
Q. And this was different again because the second TDP introduced the matrix concept?
A. Yes.
Q. And that was a very different way, because none of these, either the Pre-C, the Post-C or the first TDP, had had a schedule of values where you could process a large number of claims just by picking a category?
A. That's correct.
Q. So that was a substantial change over the prior payment plans, correct?
A. That's right.
Q. And as a matter of fact, that substantial change is probably the only reason that the Trust has been able to process and pay more than 300 thousand claims since 1995?
A. Well, there's cause and effect. You know, that change also caused 300 thousand claims, also. And then they processed the 300 thousand.
Q. That's a difference of opinion we'll explore. But you would acknowledge, without the matrix and without the changes made in the TDP, these results couldn't have been achieved,

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just in terms of sheer processing volume?
A. They would have had -- it would have been very expensive. They would have really had to have staffed up a lot in order to do that on an individual evaluation on the Post-C procedures.
Q. And you personally were working with various asbestos manufacturers in the tort system over this period of time, correct?
A. Yes.
Q. And you were working for the NGC in the early nineties?
A. NGC?
Q. Yes.
A. Yes.
Q. And you were sort of paying attention to this process. Let's turn now more specifically your market share analysis,

and I will put this down.
Your market share calculation -- let me make sure we're very clear on one point. You have a market share driven premium in your view of the world, correct?
A. Yes.
Q. Then you have a tobacco discount in your view of the world?
A. Yes.
Q. Then you have, one of the last things you talked about with Mr. Bernick, a claim of a premium or inefficiency in the
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TDP, your sort of medical audit driven inefficiency?
A. More volume than inefficiency criteria.
Q. You used something different to calculate each one of those numbers?
A. That's correct.
Q. We didn't put it on here --
A. Well, actually I should take that back. In terms of the Manville Share there is some overlap of the data that I used and the smoking discount, the same database.
Q. I think I understand that. But so what you're saying is when you do the share, you're using not only the Pre-C claims, but using that 591 that you're also using to do the smoking discount?
A. The average smoking discount, yes.
Q. So that's what you mean when you use the same data?
A. Yes.
Q. Now, counsel showed you a document -- strike that.
Your market share premium is literally just that, you talked to the jury this morning about docket pressures?
A. Yes.
Q. But you don't separately try and quantify docket pressure, you used the market share as a proxy or an explanation for how you might value the docket?
A. Well, by the time that you get to the Post-C there's also that history of higher market shares that have been driven by
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the pressure put on the Trust to settle all the claims, all of the Pre-C claims in a very short period of time.
So you have a combination of two factors by the time you get to the Post-C, both the docket pressure and at that point the prior history.
Q. But my question was really simpler, I think. It's just that when you try and calculate for this jury what the premium is based on market share, you're not doing some separate formula or statistical analysis to look at docket pressure or anything else you find objectionable about the way the Trust process its base claims?
A. Well, I didn't use the term objectionable, in the first place. But what I do is, I use 20 percent as a benchmark of what they would have paid out had they held the market share to the historic value.
Q. And your premium is all derived from whatever you think the gap is between what they actually achieved and 20 percent?
A. It's what the data showed the gap is between 20 percent and what they paid out.
Q. But you have to presume that 20 percent is appropriate, correct?
A. Yes.
Q. If the 20 percent should have really been 30 percent, that substantially reduces the premium you find, correct?

25 A. That's correct.
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1 Q. And if your calculation of the share is overstated, there
2 may not be any basis to find a premium anywhere here, right?
3 MR. BERNICK: I object to the form of the question,
4 the calculation of the share.
5 THE COURT: If you can't answer it say so.
6 A. I just missed the question. Sorry.
7 Q. That's all right. I didn't mean to suggest that you
8 calculated the 20 percent. I did suggest that -- and I
9 believe you testified you calculated the other end of this
10 equation, and all I'm trying to establish is if we close that
11 gap, the jury doesn't believe you in terms of what the
12 differential is, you don't have a basis to come in here and
13 say that there's a premium, apart from what you do in the
14 medical audit in the TDP period?
15 A. Right, if the jury believes that it should have been 30
16 percent, and if the jury believes that it actually was 30
17 percent, that would reduce the premium to zero.
18 Q. Okay. Let's look at the only document you showed the
19 jury in terms of supporting the 20 percent. This is, for the
20 record, GZ 200051.
21 It's a document called Pre-C Settlement Strategy,
22 which is a draft report prepared March 30, 1988.
23 Now, I believe counsel showed you this text, which
24 says the ten to twenty percent range -- see that, Dr. Dunbar?
25 A. Yes.
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1 Q. This is where you, in the first instance, identify the 20
2 percent, correct?
3 A. Can I read that a for a second?
4 Q. Do you need it enlarged?
5 A. Yes. I'm at an age where I can't see with either glasses
6 or not.
7 Q. This is a document you and Mr. Bernick discussed this
8 morning.
9 A. Yes.
10 Q. All right. I'd like to call the jury's attention to some
11 aspects of the document that you didn't share.
12 First, Dr. Dunbar, this is shown as a draft report.
13 Have you ever seen a final?
14 A. Yes.
15 Q. And it's Pre-C settlement strategy?
16 A. Yes.
17 Q. And the first line describes the memoranda as a strategic
18 plan?
19 A. Yes.
20 Q. And if we turn to the next page of the document, it
21 reads, the Manville Share results from a consideration of
22 historical values, market share and ability to pay.
23 So they are introducing the concept of ability to pay
24 there.
25 This process will yield an acceptable range of values
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1 wherein the Trust should be able to fairly settle cases. Then
2 they give their estimate of the range. They go on, though,
3 and say, first, historical values have undergone significant
4 changes during the period pre- 1982 to the present time.
5 Just so the jury understands, when Manville filed
6 bankruptcy in 1982, litigation against it stopped, correct?

A. That's right.
Q. So the Pre-C claims had been sitting there waiting for, by the time Trust opened its doors, at least six years?
A. Yes.
Q. In many cases longer?
A. Yes.
Q. Then it continues. It is evident that historical values can be applied in boilerplate manner to Pre-C cases. They are useful to point of comparison to the goals of the Trust's payment of the fair value in light of the reorganization.
You saw this text in the process of forming your opinion, Doctor?
A. Yes, I did.
Q. More importantly, there's a reference here to then current state of affairs. Did you read this, Doctor?
Second, the market share has been set since the 1970s when all asbestosis- containing product manufacturers ceased the production and sale of such products. This share has been adjudicated in only a few jurisdictions and at this stage in

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the litigation may be nearly impossible to determine accurately. However, there is knowledge that the Manville market share would have ranged nationwide from 0 to 40 plus percent.
You saw this in the context of forming your opinions in this case, correct?
A. Yes, I did.
Q. You know something about the way asbestos litigation works, don't you, Dr. Dunbar?
A. I believe so.
Q. And you know that market share is often determined with respect to a particular job site, shipyard, power plant?
A. Yes.
Q. And the market share in those circumstances is driven by what kinds of proof have been provided as to which manufacturer's products were present in that facility or site over which periods of time?
A. That's right.
Q. So you expect to see substantial variation in market share from site to site, correct?
A. Yes.
Q. And in some places certain manufacturers will have predominant shares and other places not?
A. In local -- if you're talking about very localized conditions, such as a particular site as opposed to a larger

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geographic area, I would say that's quite possible.
Q. Let's turn back to the document. It goes on to say that, most Pre-C cases will be evaluated based upon the Manville Share. You see that?
A. I've lost you.
Q. Right here (Indicating.)
A. Yes.
Q. Now, as a matter of fact, you looked at roughly a third of the Pre-C files?
A. Yes.
Q. And that wasn't any kind of random sample, the Pre-C files, was it?
A. For my purposes it was.
Q. Well, you were provided files by counsel, correct?
A. My --

16 Q. You don't know any more than that?
17 A. I do know a little bit more than that, yes.
18 Q. You're representing to this jury it was a random sample
19 of claim files?
20 A. I'm saying that for my purposes it was a random
21 sampling. In other words, there was nothing in the
22 acquisition of those cases to suggest bias.
23 Q. But it wasn't a random sample?
24 A. It was an unbiased sample, from my standpoint.
25 Q. Now, the document goes on to describe various things that
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1 the Trust can do. Now, one of the things is describes is a
2 green card or pleural registry system?
3 A. Yes.
4 Q. You know what that is, don't you?
5 A. Yes.
6 Q. Could you describe that to the jury, please.
7 A. One of the issues that came up early in asbestos
8 litigation was that somebody who became diagnosed as having a
9 pleural plaque might not have been able to sue to get damages
10 because they were not impaired, they could still function as
11 they had been doing before.
12 The problem arose that if there was some later date,
13 ten to twenty years down the road, when they got lung cancer,
14 then they would truly be impaired and they -- and they would
15 be due a claim but for the problem that the statute of
16 limitations might have started running from the time that they
17 discovered their illness.
18 So this seemed manifestly unfair, the person finds
19 that they have got an asbestos condition and they can't -- if
20 they sue at that time, they are not going to get any money,
21 and if they wait until some later date, they are not going to
22 get any money.
23 So a device was developed called pleural registries,
24 where a person who got a pleural condition was registered and
25 that tolled the statute of limitations.
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1 If it ever came to pass in some jurisdiction, if that
2 person got a compensable disease, there was no defense against
3 paying them based on statute of limitations, and they would
4 get paid.
5 Q. But as a matter of fact, the Manville Trust never used a
6 green card or pleural registry, did they?
7 A. That's correct.
8 Q. The document goes on to say, under heading how the
9 process will work. Given approval of the strategy for
10 valuation discussed above -- you see that?
11 A. Yes.
12 Q. They talk about their objective of settling the 17
13 thousand claims?
14 A. Yes.
15 Q. And again, there was no pleural registry ever created?
16 A. Not to my knowledge, no.
17 Q. So this is the document you shared with the jury. You
18 didn't show the jury the final of this?
19 A. I'm not sure whether we showed them the final or not.
20 Q. And on the basis of that document, you assumed that
21 Manville should have achieved a ten to twenty percent share?
22 A. No, that's not correct. I had other evidence, it just
23 wasn't shown to the jury.
24 Q. Do you have any document that states categorically that

25 Manville will pay no more than 20 percent?
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1 A. Well, no, in fact they didn't. What I was saying was
2 that an estimate of the Manville Share in aggregate would have
3 been in the ten to twenty percent range.
4 There is more than that document to support that
5 position. In any particular case it might have been 10
6 percent, in another case it might have been 40 percent, but
7 the average should have been 20 percent. That's my point.
8 Q. And at this point in time Manville had been out of the
9 tort system for six years?
10 A. Yes.
11 Q. So they lacked direct personal experience as to how they
12 would do in sitting down to negotiate cases?
13 A. Well, the claims negotiators hadn't been out of the tort
14 system for six years. Both Healey and Smith, who were the two
15 primary claims negotiators, had come over from the ACF.
16 Q. But they hadn't been negotiating on behalf of Manville?
17 A. That's correct.
18 Q. Let's look at GZ 200364. As part of the first TDP, I
19 believe you told us that a gentleman named Mark Peterson was
20 serving as a consultant?
21 A. Yes.
22 Q. And Dr. Peterson wrote a memorandum in April of 1991. Is
23 this something you reviewed in the course of forming your
24 opinions?
25 A. Yes, I did.
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1 Q. And Dr. Peterson is also an expert in mass tort matters,
2 correct?
3 A. That's correct.
4 Q. As a matter of fact, you've been in cases, both against
5 him and with him before?
6 A. That's correct.
7 Q. He writes this analysis in '91, and he makes some
8 observations about Manville Share. Did you consider this
9 observation: "We cannot make a definitive current calculation
10 of the Manville share because co-defendants maintain the
11 confidentiality of their settlements."
12 A. Did I consider that?
13 Q. You were aware of that; it's hard to get market share
14 data?
15 A. Well, I'm aware of the problem. I'm not sure that it was
16 a -- I think the problem is that both Mark and I have market
17 share data. It's just that it's private. It's under -- it's
18 confidential, and so you can't really --
19 Q. You can't share it?
20 A. Right, you can't publish the information very easily.
21 But he and I are, I think we have access market share data.
22 Q. You see here, you were aware that he calculated that
23 Manville had paid a 30 percent share?
24 A. That's correct.
25 Q. And nowhere in this document, Dr. Dunbar, does he
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1 criticize Manville for having done that, does he?
2 A. No, I don't believe he does.
3 Q. As a matter of fact, he finds under certain circumstances
4 Manville may have paid less than 30 percent, correct?
5 A. You mean depending on how you estimate the share? He
6 took out the 85 percent --

Q. The Manville only claims.
A. That's his definition of Manville only.
Q. Is that the definition you use?
A. What he did is he took out both 85 percent on one calculation and 100 percent on the other in order to see if you had a different definition of Manville only, if that affected the Manville Share.
I don't have an opinion on whether one of those or the other is the best way to do it.
Q. He concludes on page 4, indeed, it is likely that the Manville Trust actually averaged less -- and I'm supplying the missing text, there's a hole there -- less than 30 percent of the payments for these pre-bankruptcy claims, and he talks about the fact that other later co-defendants' settlements would reduce the Manville Share.
I don't think he talks about it right there but in this memo he does.
A. Sorry. Let me try to take a look at that if I can.
Yes. But that wouldn't affect my calculations.

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Q. So you have the Pre-C settlement plan and that, in your view, supports the idea of a 20 percent share, I guess you also say, anticipated or estimated 20 percent share in the aggregate?
A. Yes.
Q. You're not talking about individual claims?
A. Not talking about any individual claims, right.
Q. I'm going to show you GZ 200053. This is a Trust document for people doing claims work. It says, a detailed explanation of market share will be required only for unusual market share authority requests. Unusual is defined as higher or lower than the 25 to 35 percent which encompasses the great majority of Trust values.
You see that, Dr. Dunbar?
A. Yes.
Q. So at this time they were defining claims outside that range as unusual, if you were in the 25 to 30 percent, that was a usual or typical value?
A. I agree that later on it had been negotiated up past the 20 percent mark.
Q. I think you talked some about Mr. Smith and his testimony?
A. Yes.
THE COURT: How much longer is this going to take?
MR. STENGEL: I've got probably another hour and a

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half, your Honor.
THE COURT: You do. We'll break for lunch. Be back at two, please.
(Jury leaves the courtroom.)
THE COURT: Any applications?
MR. BERNICK: I suppose we should take up the question of the deposition of Dr. Harris at some point.
THE COURT: You said you didn't want to take his deposition.
MR. BERNICK: Well, the way that you put the question to me suggests that I ought to seriously consider that.
My hesitation is very simple. It may be something where the court can provide some assistance. I would like to take Dr. Harris' deposition. The problem is that every time

we set up an opportunity for discovery, what happens is we walk into the deposition and all of a sudden the work gets expanded even more.

Then if I ask a question, well, I have had the opportunity to ask the questions. If I don't ask the questions, well, I should have asked the questions. I really believe that this is a situation where the problem is not of our manufacture and we should not be the ones to bear the burden from it.

He's going to testify about CPS-II, he's going to

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testify about the jump in the data in 1962 based upon the NHIS analysis, I guess, and if he's going to talk about in general terms he feels that the underlying --

THE COURT: He looked at those documents, and I'm going to let him testify about what he found. He's a medical doctor as well as a statistician --

MR. BERNICK: I don't believe he looked at the documents. What he says he looked was at raw data. It was not the underlying files themselves.

THE COURT: That was not my impression.

MR. BERNICK: It's not the underlying data. It's a different dataset --

THE COURT: Excuse me. If he looked at data which was available, I'm going to allow it. If he looked at new data, of course I'm not.

MR. BERNICK: The record I believe is absolutely unequivocal that we did not have what he put his eyes on. You say we had it. We did not have it. I can't cross-examine him with respect to that underlying data.

MR. STENGEL: Our records indicate they had it. We will provide them the codes and identify --

THE COURT: You want to take his deposition, take it. He is going to testify.

MR. BERNICK: The question, your Honor, really is what is he going to be permitted to testify about?

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THE COURT: He's going to be permitted to testify on every element that he was challenged by Dr. Wecker.

MR. BERNICK: What is it, your Honor, that enables us to know -- I'm not intending to quarrel with the court --

THE COURT: I can't try your case. I have already, I believe, probably interceded too much, because I have a great respect for you and you seem upset, and I don't like any lawyer in my courtroom to be duly upset.

MR. BERNICK: I'm sorry if I seemed upset, your Honor. What I'm trying to do is to solve a problem. The problem is, we now have an expert who has done further work in this case.

It's an expert who has demonstrated his willingness and ability to do voluminous amounts of work, and we are absolutely incapable of doing the same amount of work and respond to it in time to conclude our case.

THE COURT: I can't give you any more detailed analysis of what he's going to say.

MR. BERNICK: I guess what I would like is the answer to two things that might be helpful, and I don't mean to offend the court.

Number one, with respect to the POC opinions that he has, we have these computer files that he turned over last night. As I understood your Honor's inclination this morning,

he was --
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THE COURT: Those parts that Dr. Wecker says will take him months to analyze, those runs I don't want him to testify to.
MR. BERNICK: So there will be a general opinion about whether the new information or the old information that he has seen supports his views, but we're not going to get into the computer run?
THE COURT: That was my impression this morning. Yes. I don't know enough about the background or the science to give you more direction at this point.
MR. BERNICK: The matters that he listed were three that we have talked about. Those are the only ones as to which we have received now any material at all. Will that be it?
THE COURT: If you haven't received the material by today, up to this point, I won't permit him to testify, yes. We have to have an end to it.
MR. BERNICK: Then we will proceed to take the deposition. We would like the deposition to take place here in New York at our convenience.
We're getting ready for closing arguments in this case, and it's very important that --
THE COURT: Try to work it out. He is a human being, besides being a scientist, and I'm sure he has problems at home.
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MR. BERNICK: We still do not have the Trust's numbers in this case.
THE COURT: I understand.
MR. BERNICK: Thank you.
THE COURT: All right. Thank you. I will see you at two.
(Luncheon recess.)
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A F T E R N O O N S E S S I O N
(Jury not present.)
THE COURT: I must say -- I am not saying this critically of the cross-examination -- sit down, please -- but I don't understand where it is going. I don't understand what all of this talk about whether the tobacco portion was

considered or not considered. That's not the theory, as I understood it, of the case.
MR. STENGEL: It is not.
THE COURT: As I understood the theory of your case, it was that there were more serious and more claims. So the fact that the tobacco is in or out, as far as I can see, it has nothing to do with it. It is a lot of smoke, as far as I can see.
MR. STENGEL: That's our view.
THE COURT: There is one part of the case that was gone into on direct, and the witness did direct his attention to it. That is, the question of whether the number and seriousness of the claims were affected.
I have no view about it, but I don't want cross-examinations that have no bearing, if they don't. But you can do whatever you wish with your cross-examination.
(Jury present.)
THE COURT: All right. Proceed, please.
MR. STENGEL: Thank you, Your Honor.

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Good afternoon, ladies and gentlemen.
EXAMINATION CONTINUES
BY MR. STENGEL:
Q. Doctor Dunbar, how are you?
Before we move off the subject of your market share premiums, let me ask you a couple of questions about the analysis that Doctor Peterson did in 1991. Do you remember that?
A. Yes.
Q. All right. At the time Doctor Peterson wasn't working for any party, was he?
A. That's correct.
Q. And he was closer in time to events than you certainly are sitting here today, is that correct?
A. Closer in time, yes.
Q. So you don't as you sit here today have any reason to take issue with Doctor Peterson's calculation of a 30 percent or lower market share for Manville, do you?
A. Well, I don't have reason to take issue with his calculation, but for the fact that in my sample of cases, we ended up with a higher average.
Q. But from a methodological or other perspective, you can't as you sit here today point out any deficiency or flaw in what Doctor Peterson did?
A. I can't do that because methodologically, the memos that

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we have from Doctor Peterson don't actually spell out the methodology.
Q. Okay. I will take that -- you got a different number so you don't know?
MR. BERNICK: Objection, to the form of the question.
THE COURT: Sustained.
Q. Doctor Dunbar, just confirming, you don't have any other calculated basis for your market share premium other than what you did with the preC and post-C cases?
A. I haven't calculated any other premium than what has been presented here off of the preC and the post-C data.
Q. Okay. Let's turn to another subject, which is the so-called smoking discount. We will talk about why that matters in a moment but let make sure that we are on the same

page and on couple of reasonably important issues.
You agree, don't you, Doctor Dunbar, that the effects of smoking asbestos exposure have a multiplicative effect on the development of lung cancer?
A. Well, I take that as a given.
Q. You have actually written that in your book, and unlike Mr. Bernick, I have opened it.
A. I think what I say is that dose response relationship in lung cancer is multiplicative. By that all I mean is that you multiply relative risk times background risk to come up with
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the overall risk. That is a little different than saying the asbestos tobacco synergy is multiplicative.
Q. Just so there is no mystery, I will mark this as Dunbar two and at page 109, you in fact write, the effects of smoking asbestos exposure have a multiplicative effect on developing lung cancer; is that correct?
A. Yes.
Q. You also give an attributable risk to smoking of 80 percent, correct?
A. That could be. I don't remember.
Q. And the question I have for you, Doctor Dunbar, and the one that I would like to share with the jury is, you put up some graphs and -- let me withdraw that.
You understand that the theory of the plaintiffs' case is that by virtue of conduct of the tobacco companies, the Trust is faced with more and sicker claimants, correct?
A. Yes.
Q. Let me -- and I would -- with apologies to defendants, I have marked up one of your overheads, and you posit this world with these people who smoke and you have asbestos. But all --
THE COURT: What number is that you are putting up?
MR. STENGEL: We will call this Dunbar three, Your Honor.
THE COURT: It had better be Dunbar plaintiff two and Dunbar plaintiff --
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MR. STENGEL: It is plaintiffs' Dunbar three, Your Honor.
THE COURT: Yes.
Q. Now, you explained, I think, how an aggregate number would work, but I want you to do what economists do, which is hold everything else equal and if you assume we have the TDP in place and you assume that hypothetically, although it is not a real number, lung cancers are being paid twelve thousand five hundred dollars each.
A. Okay.
Q. And the expectation was that these eight claimants would arrive at the Trust and my question is very simply, if claimants nine through one hundred arrive and the Trust is still paying each claimant twelve thousand five hundred dollars, what does each of the additional claimants cost the Trust?
A. I'm -- each additional claimant costs the Trust in this world twelve thousand five hundred dollars.
Q. Thank you.
You talked briefly this morning about claims under the TDP, that there were certain claims that you didn't think were adequately documented?
A. Yes.
Q. I would like to discuss that with you, if we can.

25 You put up a chart with a series of doctor's names
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1 and some percentages?
2 A. Yes.
3 Q. The source of that chart was a single letter from Mark
4 Ledderer to Elihu Inselbuch. That was a letter written in
5 1998?
6 A. Sounds right.
7 Q. We will mark this as plaintiffs' Daubert four, or Dunbar
8 four, excuse me.
9 In this letter, -- well, first of all, Mr. Ledderer
10 describes the process as being downgraded because of their
11 X-ray results?
12 A. Correct.
13 Q. Which means they got paid less?
14 A. Paid -- got paid less, if anything.
15 Q. Some of them didn't get paid anything at all?
16 A. Correct.
17 Q. In fairness to Mr. Ledderer, his analysis was described
18 as my analysis has been briefly discussed with the staff at
19 the Trust, but my methods are now and have not yet been
20 replicated.
21 You see that, sir?
22 A. Yes.
23 Q. He talks about unclarity about what's going on and he
24 says there may be no doctor bogus, outright fraud, something
25 very much more complicated going on.
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1 This was a preliminary assessment of Mr. Ledderer,
2 correct?
3 A. I am not exactly sure the part that I used would be
4 called preliminary. I think the part that I used had been
5 substantiated in terms of the numbers since 1995.
6 Q. Well, the numbers you used related to an assessment of
7 what's called B-reader invariability, correct?
8 A. Yes.
9 Q. That means in the -- the jury I think has heard a little
10 bit about ILO score and X rays, probably more than they want
11 to, in that sense what was being analyzed was how often the
12 doctors you listed for the jury match other B-readers,
13 correct?
14 A. Matched one out of two, yes.
15 Q. And are you aware of the study commissioned by the Trust
16 from Penn State University assessing the fairly high degree of
17 B-reader invariability that exists?
18 A. I am very aware of that study and it said that with
19 regard to doctors, this is an accurate approach.
20 Q. And you are aware that the Trust took steps to press
21 forward with medical audit and ultimately determined that the
22 medical audit was not adequate for their purposes?
23 A. Well, I would dispute the characterization.
24 Q. Well, did you look at documents sent to the Trust by
25 people outside the Trust, like plaintiffs' lawyers, about the
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1 B-reader issue?
2 A. Yes.
3 Q. And as a settlement trust, the Trust has to take into
4 account the views of those people, correct?
5 A. I think that's a sweeping generalization. I wouldn't
6 necessarily go along with that.

But I think the optimal trust design is one where you go along with them up to an extent but where one group of plaintiffs' attorneys are disadvantaging say the future claimants, then I don't think you do go along with them.
Q. You yourself are not an expert in evaluation of ILO scores or X-ray review?
A. That's correct.
Q. Do you have -- strike that.
So you did this entire calculation, the only quantification you have re problem with claims in the TDP, based on the attachment to Mr. Ledderer's letter?
A. The -- yes. The quantification is -- comes from that data. But it is verified by a lot of other data that I have seen.
Q. Okay. It was based solely on Mr. Ledderer's description of the results of that subset of documents?
A. Again, the quantification comes from that particular letter.
Q. You didn't do any quantification of issues relating to
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the conduct of the Trust under the TDP?
Strike that.
You actually think the Trust is fairly effective under the TDP, correct?
They do a pretty good job of processing?
A. Would I say that?
Q. Yes.
A. Well, I think they're efficient at handling the claims. I think they handle way too many because of the design.
Q. The design being the disease criteria of the TDP?
A. The relative to say design such as came out of the Georgine settlement which I think is a much better design for handling claims.
Q. But in fact the Manville Trust has become a model for other asbestos facilities, has it not?
A. To an extent.
Q. Well, Doctor Dunbar, let me show you what we will mark as plaintiffs' Dunbar five which is, for the record, the disclosure statement with respect to the Celotex bankruptcy and I have marked annex B, Doctor Dunbar, and just ask you to look at the disease criteria that are in the Celotex plan.
MR. BERNICK: Your Honor, I object.
I think that that is entirely irrelevant and it's hearsay. It is offered for a purpose or to establish a proposition that's not at issue through this witness. We are
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not arguing, this witness is not here to say that at the present time the TDP values that were used by the Manville trust are somehow different from values that are used by another trust, which is the purpose for which we think this has been offered.
The question is what those values actually represent. The fact that they are used by another trust doesn't make any difference so I don't know what the purpose of that. It goes beyond the scope of the examination. It is also irrelevant to the case.
THE COURT: The witness, as I understood it, has criticized the operations of the Trust as well as the TDP. He is being asked to look at this for purposes of veracity.
MR. BERNICK: I didn't understand that to be the proffer of the question. But maybe I didn't hear it

16 properly.
17 THE COURT: As I understand it.
18 Q. You can look at the criteria. They are identical, are
19 they not, to the TDP?
20 A. Yes, they are.
21 Q. You know Celotex to be another very substantial asbestos
22 defendant, at least it was?
23 A. That's right.
24 Q. Are you aware that Dean Macchiarola testified in this
25 court that the medical audit had been abandoned because it was
page 5832
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1 not capable of distinguishing adequately between people that
2 should be paid and people who should not be paid?
3 MR. BERNICK: I object to the characterization of the
4 testimony. The testimony could be shown.
5 Q. This is page 1342 of Macchiarola. Question by
6 Mr. Bernick:
7 There is no medical audit. You can't represent that
8 the TDP claims are bona fide. Can you?
9 Answer: That's part of our difficulty. The medical
10 audit was unable to distinguish between bona fide and non-bona
11 fide claims, no matter what, because the disease was not
12 susceptible to a foolproof determination.
13 The medical audit was not, in and of itself, able to
14 give us the information that would allow us to discard only
15 claims that were not bona fide. Medical audit would also
16 eliminate claims that were bona fide. And that's what the
17 witnesses -- that's what our experts told us when they
18 examined the medical audit.
19 Were you familiar with that testimony?
20 A. Yes.
21 Q. Doctor Dunbar?
22 A. Yes.
23 Q. You have never been a trustee before?
24 A. No.
25 Q. You've never been responsible for running a facility that
page 5833
page 5834
1 has as its obligation the compensation of hundreds of
2 thousands of claimants?
3 A. That's fair.
4 Q. You know that Dean Macchiarola does in fact have that
5 responsibility?
6 A. Yes.
7 Q. I would like to talk to you about this period of time we
8 moved from preC into the TDP in the negotiations because when
9 you and Mr. Bernick talked about the transition, there were
10 some values or language I think was omitted.
11 You don't dispute that the criteria and values in the
12 TDP are reflective of not only historical value but what was
13 happening in the court system?
14 A. I would agree with that.
15 Q. So it's not just historical value?
16 A. Right. I think I mentioned the issue with the pleural
17 values to show that.
18 Q. If we were to look at the TDP, and I am referring to
19 plaintiffs' 75500.018, and if we look at category two,
20 non-disabling bilateral interstitial lung disease. I will put
21 this here, so you have it in mind.
22 Now, nothing in the TDP -- you need to see the rest
23 of the -- right here.
24 Would you like to see the rest of the criteria? I

would be happy to turn the page for you.
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page 5835
A. I just need the question.
Q. There is no reference under category two or any consideration of smoking, is there?
A. That's correct.
Q. So smokers and non-smokers get paid exactly the same under category two?
A. In the TDP.
Q. In the TDP.
If we were to look at category three, which is disabling, that's also true, isn't it?
A. Yes.
Q. And if we turn to categories five and six, while smoking is considered the -- you can't take issue with the fact that of the Manville Trust claimants approximately 85 percent of those claimants qualified in category six, which is the more expensive category?
A. That's correct.
Q. Leaving rationally 15 percent in the lower value category?
A. That's right.
Q. You are also aware, are you not, that 80 to 90 percent of the Manville Trust clients are -- claimants smoke?
A. That sounds about right.
Q. So functionally, the distinction between categories five and six is clearly not a smoking discount, correct?
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A. I would disagree with that.
Q. But do you know whether there is a statistically significant difference between what non-smokers and smokers receive under the TDP?
A. Well, I've never tested that, no.
Q. So you can't say as you sit here today?
A. No.
Q. Now, I want to talk to you about this notion of an aggregate discount for smoking in the TDP. I think you have told us that -- well, certainly -- strike that.
There is no discount at all in the TDP for the two categories of bilateral interstitial disease, correct? Explicit in the TDP?
A. Well, the -- there are two different issues there. There is a discount for smoking because it is based on historical values. But if you are a smoker and you come to the TDP, smoking is not a criteria for either the 25,000 or the $50,000 claim.
My point is that the reason they are 25,000 and 50,000 is because smoking reduced the average value of asbestosis claims prior to the TDP.
Q. Let's talk about the derivation of your average value. That's your measuring stick here.
That, again, was calculated from the 591 claims as to which you had the CAS forms?
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A. I think that's seven hundred claims, actually.
Q. All right. Well, how many non-smoking lung cancer claims did you have for the preC period -- pre and post-C period in the sample of claims that you used to calculate these averages?
A. I don't know the number offhand.

Q. Let me hand to you, if I can find it, something which I think would refresh your recollection.
I will mark this Dunbar six, plaintiffs' Dunbar six.
I draw your attention to the second page of the exhibit, doctor.
A. You want me to count these?
Q. It looks like ten to me.
A. That's correct.
Q. So all of your -- this is as to lung cancers?
A. Correct.
Q. All of your calculation of averages and projections and comparisons between smokers and non-smoking lung cancer claimants relies on ten non-smokers for the entire pre-TDP period?
A. No, that's incorrect.
Q. Isn't this the basis of the average you have calculated and presented to this jury?
A. No.
As I have pointed out I think in -- I'm sorry if I

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wasn't clear, what we came across was the Peterson averages or the Peterson recommendations of the seventy thousand versus the one hundred and twenty thousand. So that -- those were the numbers that were being offered in the TDP process.
We then went through and calculated our own averages from the data that were available in the sample that the plaintiffs in this case had drawn and we verified the Peterson averages with that sample.
Now, also with regard to things like the average discount for smokers, off of the CAS forms, again, that's a five hundred and ninety sample. That's not a sample of ten. With regard to the correlation, again, that's another large sample. That's a five hundred ninety sample.
A lot of the calculations are based on much larger samples than that.
Q. Doctor, you went somewhat beyond my question.
My question was, and this is in fact a listing of the claims as to which you have CAS forms, is that correct?
A. For which we have both CAS forms with recommended amounts and paid amounts.
Q. Right.
So although there may have been larger samples to do other things, when you did your calculation of averages, not when you looked at Doctor Peterson's estimate, when you did your calculation, all of your calculation of averages used ten

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non-smoking cases?
A. Right, but the --
Q. Simple question.
A. It is an average that includes -- the seventy-three thousand average, okay, that includes -- I think that's something on the order of seven hundred, and in that seven hundred there are ten non-smokers.
Q. I am just looking at the comparison between smoking and non-smoking.
When you get your eighteen thousand five hundred number you point to as giving consistency with what Doctor Peterson indicated was a midpoint expectation, that eighteen-five comes separate off this list of ten cases, correct?
A. That is exactly precise.

Q. Right. That's what I was trying to do.
So again, your average, the eighteen-five you have shown to the jury this morning, relies on ten cases out of 27,000 cases resolved in the preC period or preTDP?
MR. BERNICK: I think he's answered that question. He's also answered it in the proper context.
THE COURT: Next question, please.
Q. Now, Doctor Dunbar, we talked a little this morning about the negotiations in the TDP and the various groups that were involved. Do you remember that conversation?

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A. Yes.
Q. And we also talked this morning about the fact that in the preC and post-C period, there were negotiations going on between plaintiffs and defendants, and the discounts that you claimed to have identified in the pre-TDP period, if you had lung cancer and were a non-smoker, you won't get a smoking discount, would you?
A. No.
Q. Now, you come in here and posit a very different outcome for non-smokers under the TDP, correct?
If you're an asabestotic who doesn't smoke, you get a discount, right?
A. Yes.
Q. All right. And with all of the time and effort that went into the negotiation of the TDP, have you seen any piece of writing or testimony or notification suggesting that claimants, that even if they're non-smokers they are going to suffer a smoking discount?
A. Under the TDP?
Q. Yes.
A. No. That would be an irrelevant question.
(Continued on the next page.)

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BY MR. STENGEL:
Q. Okay.
A. Before BID, smoking is not part of the criteria.
Q. Right.
A. My point is that the BID values have been brought down by the smoking discount that occurred prior to the TDP.
Q. But you presumed that the TDP was negotiated by lawyers who had nonsmoking clients, correct?
A. I'm sure they had some.
Q. Wouldn't you expect those people to object if their clients were getting secret discounts forced on them?
A. I suspect that there were all kinds of clients who were disadvantaged by the TDP because, for example, they might be from a jurisdiction, such as Mississippi, where they would get higher claims values. They may have had more dependents. They may have been younger.
There's a lot of reasons why people would have had higher, sometimes much higher, claims values than are on the matrix. But the Trust made a decision to simplify things and one of the simplifications was that there were only seven values.
Q. My question is really more simple, Dr. Dunbar.
You've given the jury references to some documents that talk about historical values in the TDP?

25 A. Yes.
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1 Q. You've shown them that the numbers, at least in raw
2 terms, the way you calculate them, seem to correspond?
3 A. Yes.
4 Q. But you would admit that imposing an overall smoking
5 discount on every Trust claimant would be a substantial change
6 from the world before the TDP, correct?
7 A. You have to tell me what you mean by substantial.
8 In the case of asbestos, it's a 14 percent change.
9 And in the case of lung cancer there's still a smoking
10 discount.
11 Q. But that would matter to claimants, wouldn't it?
12 A. Yes, it would matter to claimants. It would matter to
13 any claimant that they think has a better claim than a TDP
14 value.
15 Q. And all I'm asking is other than references to historical
16 value and the numbers eyeballing the same way, can you point
17 us to a piece of paper, memorandum or letter, that says
18 there's a secret discount under the TDP for smokers?
19 A. No. Nobody said that directly.
20 Q. And you can't cite any negotiations where that issue was
21 specifically discussed?
22 A. The smoking issue?
23 Q. Right.
24 A. I don't recall anything.
25 Q. So, we move from an environment where only smokers got
page 5842
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1 discounts to one where everybody gets a discount and nobody
2 says anything about it?
3 A. Well, again, nobody said anything about the very young
4 people that get paid or the people with six dependents.
5 There's a lot of people who were disadvantaged by the TDP and
6 a lot of people who got a benefit from it.
7 Q. Let me ask you one other question about smoking and its
8 significance.
9 You wrote something before your book on estimating
10 future claims?
11 A. Yes, I did.
12 Q. That was written in 1992?
13 A. Yes.
14 Q. And that was written before you were retained by any
15 tobacco company?
16 A. Yes.
17 Q. And when you did the analysis that's reflected in here
18 you talked about valuing asbestos claims?
19 A. Yes.
20 Q. And you even presented the results of a regression
21 analysis that you had done, correct?
22 A. Yes.
23 Q. And in the course of presenting that regression analysis
24 you shared with the reader the six variables that were
25 important to determining value under the regression analysis,
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1 correct?
2 A. That's correct.
3 Q. And those variables were age, occupation, disease,
4 jurisdiction, share of settlement and year of filing, correct?
5 A. Yes.
6 Q. And nowhere in that list created before you were retained

by a tobacco company is there any reference to smoking being an important variable, as the Nera regression analysis, to determine the value of asbestos claims, correct?
A. That's correct. I can explain if you want.
Q. I think we understand.
MR. STENGEL: Nothing further, your Honor.
THE COURT: Thank you.
Make your redirect very brief, please.
MR. BERNICK: I'm sorry.
THE COURT: Very brief, please.
MR. BERNICK: Okay.
REDIRECT EXAMINATION
BY MR. BERNICK:
Q. To save time, Dr. Dunbar, on the question of more claims and more severe claims, I want to mark DEM 012137 and 38 and ask you whether those are the charts that Mr. Stengel marked up and we'll just offer them into evidence instead of taking further time.
MR. BERNICK: DEM 012137 and 8.
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THE COURT: And 8; 38 or 8?
MR. BERNICK: 37 and 38.
THE COURT: Okay.
MR. BERNICK: We'll offer them in and we can argue from them later on.
(So marked.).
Q. The whole question that was raised by the Dr. Harris model, what if there were less smoking would there be less severe and fewer claims, that's the counter factual world question Mr. Stengel asked you about that. In point of fact, have you done a whole analysis of what would happen if there were actually less smoking?
A. Yes, I have.
Q. And if there were less smoking, the discount would have been smaller?
A. The discount would have been smaller, so the average values would have been higher.
Q. Then what would happen to the volume of claims?
A. The volume of claims goes down if there's less smoking. No doubt about it.
MR. STENGEL: Your Honor, this is not redirect. This is a whole new line of questioning.
THE COURT: No. You can ask one or two questions and then move on.
A. The volume of claims would go down if there's less
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smoking. But because each claim is now being settled for a higher amount, because there is less smoking, the total amount that the Trust pays now is equivalent to what the Trust would pay if there was less smoking and that's an evaluation which I did.
Q. Mr. Stengel asked you whether in your book you put down the attribute risk from smoking for asbestos workers -- was it eighty percent?
A. That's what he said.
Q. At the present time, even if you assume that tobacco were eighty percent of the problem, has the Manville Trust even come close to paying the 20 percent that would be theirs?
A. No.
Q. You were asked about the medical audit and somehow whether the medical audit was resolved.

Actually, you were asked about problems of variability in the ILO as being one of the things that was uncovered in the medical audit. Is variability in the ILO a tobacco problem or an asbestos Trust implementation problem?
A. Well, in this case, it's an implementation problem.
Q. The problems that were noted in the TDP through the medical audit, counsel brought out that well, somehow, the medical audit no longer was followed by the Trust. Were the problems that gave rise to the medical audit -- did they ever go away?

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A. No.
Q. Is that what you have tried to analyze?
A. Yes.
Q. It was brought out that there are a huge number of claims in the TDP compared to the small number of claims earlier. Does that change any part of your analysis at all?
A. No. The sample sizes that we have are really pretty large, given modern day statistical methods.
Q. All the sample sizes that were referred to, are they statistically significant samples?
A. Yes.
Q. And the 300,000 claims, the fact that there are 300,000 claims, does that say that the system is working well or poorly or can can't you tell?
A. Just by saying the number 300,000 you can't tell one way or another. You do have to go in back of the numbers to find out what's going on.
Q. You were asked some questions about the tort system values. You testified that there was the historical values that were then carried over to the scheduled values and the TDP and you were asked on cross-examination, didn't the tort system play a role as well.
Could you just tell us exactly in what respect the tort system played a role and whether that has any impact on your opinions?

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A. The reason the tort system played a role was because when the values were set by the Trust they wanted to prevent people from opting into what's called individual evaluation. There are some people who are actually evaluated individually in the TDP now. What they wanted to do is to set those values at a level that would kind of prevent that so they couldn't lower the values or else people would want to go into individual evaluation. So there was an incentive to use historical values and market values.
As a result of focusing on market values, they dropped the value of the plural claims below the average.
Q. The plural claims?
A. Yes.
Q. Are the plural claims any part of your analysis of this case?
A. None.
Q. There were questions about the TDP schedule itself and you were asked a bunch of questions about how these categories relate to one another?
A. Yes.
Q. Does that have any bearing on the tobacco portion or the tobacco share that was shaved off by virtue of the aggregated value of those categories?
A. No. If there would have been less smoking those averages

25 would have been higher and the TDP values would have been
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1 higher and they would be paying more today per claimant,
2 offsetting the decline in the number of claims.
3 Q. Specifically, there were a bunch of questions about what
4 the prices actually were of these categories and the
5 relationship between the categories?
6 A. Yes.
7 Q. Does that speak at all to the tobacco share that had been
8 taken off the top historically?
9 A. No.
10 Q. Does your analysis of the tobacco share and the fact it
11 was taken off historically -- is that affected at all by the
12 per pricing questions that were asked by counsel?
13 A. No. You could have one category for the lung cancer
14 claims and the result would still be the same.
15 Q. You were asked whether the seventy-three is the average
16 lung cancer claim under the TDP, whether that average was
17 based on the sample of only ten. I'm not sure you got a
18 chance to address that flat out. Would you answer that
19 question?
20 A. That seventy-three thousand is based on a sample of about
21 700 I believe.
22 Q. Two more quick areas. One directly driven by this. If
23 you take a look at the period of time, you were asked kind of
24 about negotiation dynamics. How could it be that if the
25 discount were actually already in place some people that were
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1 associated with the TDP weren't complaining about it or
2 questions to that effect, do you recall?
3 A. Yes.
4 Q. From the point of view of negotiation dynamics, if you
5 are negotiating a new deal, tell us what the significance is
6 of history?
7 A. What you needed -- what the Trust needed was a matrix
8 that they could sell to the plaintiffs' bar. That's a direct
9 quote by the way. And so they needed a matrix that the
10 plaintiffs' bar could say would be based on some touchstone,
11 that there was a rationale for the matrix and the rationale
12 that was built-in were these historical values and as I said
13 before there was a motivation not to reduce those values
14 because otherwise people would have opted into individual
15 evaluation and you wouldn't have gotten the benefits of the
16 matrix system.
17 You would be back in the evaluating claims
18 individually like they were doing not post-C period.
19 Q. Before the TDP, is it true that most claimants against
20 the Trust were smokers?
21 A. Yes.
22 Q. Is it true that before the TDP there was a discount for
23 tobacco?
24 A. Yes.
25 Q. And tell me whether or not there was a lot of paperwork,
page 5850
page 5851
1 a lot of documents, specifically generated talking about that
2 discount?
3 A. There were.
4 Q. Under the TDP, is it true that most people are smokers?
5 A. Yes.
6 Q. Is it true that the discount carried forward?

A. Yes.
Q. Did you see a single shred of paperwork that said we're now going to raise the prices in order to pay for tobacco?
A. None.
Q. And given the fact that most people are going to be smokers, either way, from the point of view of negotiation dynamics, the 80 or 90 percent of people who are already smokers, is it going to make a difference to most people that a discount is simply continuing through?
A. Yes.
Q. One last area.
What was the market share that you calculated that Manville actually did pay?
A. About 36, 37 percent, in that range.
Q. This 10 to 20 percent market share, as you pointed out, was estimated at the beginning. Was that solely on the basis of that one document?
A. No.
Q. In fact, if we want to, can we go to the testimony of
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Greg Smith and find the same market share and the fact that he thought it was a reasonable estimate?
A. Yes.
Q. If we wanted to go to Trust document 0015077, June 1988, would we find that Dennis, who is another claims guy, said that the ACF generally paid 80 to 90 percent of total value on settlements, which would again leave 10 to 20 percent to Manville?
A. And of 56 other defendants that are not in the ACF.
Q. If you go to documentation outside of the Trust, is it true that when settlements were taking place outside of the Manville Trust that agreements were reached between non-Manville companies about what the Manville share would be?
A. Yes, that happened.
Q. And when these people, who were not even Manville Corporation, agreed about what the implicit Manville share was, was it 30 percent or 40 percent or was it less?
A. 7 to 13 percent in a few cases in 1990.
Q. In more documentation, every time there was a negotiation in the first instance, every time there was a negotiation, did the Trust take the position that the market share was between 10 and 20 percent?
A. In the beginning they did, later on it went up. But in the beginning, in May of 1988, they were doing that.
Q. You were asked whether the fact that the market share
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rose to 30 percent might be due to inflation. Did inflation drive market share?
A. No.
Q. Why not?
A. Market share doesn't go up with inflation. If there is inflation then everybody goes up the same amount, so the market share stays the same.
Q. You were asked, gee, isn't it true, the real market share, it really was the case, that there was real information saying that the market share of Manville actually was higher. Did you see any documentation or any analysis by the Trust that said, no, the real market share, what Manville really was responsible for out there in the marketplace, was actually 36 percent or 30 percent?
A. Nothing like that.

Q. Let's talk about another possibility, which is that this rise was caused by negotiation. Is that what you have seen in all of the documents that you have seen?
A. Yes.
Q. And if there's negotiation there are people who have a stronger position and people who have a weaker position in negotiation?
A. That's correct.
Q. Can you tell me whether the Trust made a very significant decision in early 1988 that weakened its negotiation position?

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A. It did.
Q. What was that decision?
A. It became a very motivated negotiator. It's like motivated buyer or motivated seller. It motivated itself to try to settle all of the 17,000 pre-C claims before the consummation of the Trust. Given that they started out in May, they really had only a few months to do that. So they were a motivated negotiator. They had to settle things quickly under the philosophy in which they were working.
Q. Was that a decision that was required by the plan of reorganization?
A. No, this was not.
Q. Was that a decision that was -- that had anything to do with tobacco at all?
A. No.
MR. BERNICK: Nothing further.
MR. STENGEL: Nothing.
THE COURT: Step down, stir.
(Witness excused.)
THE COURT: You can take a break.
I want Mendelsohn to take the stand.
(Jury excused.)
THE COURT: Where is the doctor?
Oh, she's coming in. I want her out of here today, finished, direct examination and cross-examination.

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MR. BERNICK: It's all cross-examination.
(Recess.)
(In open court; jury present.)
SARA MENDELSOHN, resumed.
CROSS-EXAMINATION
BY MS. KEARSE:
Q. Good afternoon, doctor.
A. Good afternoon.
Q. I'm going to start off by saying I have a terrible cold and they tell me I have an accent up here. This is going to be interesting. It's Friday afternoon. We will try and get through this quickly because I don't think my voice is going to last a long time.
Doctor, can you see okay? Do we need to move the screen?
A. I think I'm okay.
Q. You can see this right here?
A. Yes, so far.
Q. I would like to start out just a little bit to figure out where we're going to be going today.
THE COURT: Mark that, please.
MS. KEARSE: I'm going to mark it Plaintiffs' M 1.
Q. Doctor, we're going to be talking about exposure and once we have exposure you'll agree we can go to a subclinical level

25 before we get to a clinical level?
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1 A. It could occur that way.
2 Q. And then we go down to a clinical level where you can
3 actually see?
4 A. Where you can make a diagnosis of clinical asbestosis.
5 Q. And then, doctor, I think you said yesterday, even at
6 times, even after, clinical asbestos-related disease can lead
7 to death, including asbestosis?
8 A. Not necessarily. In severe cases it may progress to
9 that.
10 Q. Or just clinical impairment. Okay.
11 Doctor, in between here and here, is that what we
12 call latency, between the time of exposure and the time we can
13 actually see the clinical diagnosis?
14 A. From the initial, from the beginning of exposure, until
15 when a clinical diagnosis is made, that would be the latency
16 period.
17 Q. We have latency. Okay.
18 (Continued on next page.)
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1 Q. Doctor, you agree with me that in between this period of
2 time, between exposure and when you're able to see a clinical
3 diagnosis setting in your office, there's a lot going in
4 between here in the lungs because of the latency period?
5 A. Certainly there are changes that occur in the lungs that
6 will eventually cause the clinical disease.
7 Q. Doctor, are you here to say that in between this period
8 and this period there is no disease?
9 A. There's no clinical disease.
10 Q. Is there any disease at all?
11 A. Well, I wouldn't call it disease. There are changes that
12 occur in the lungs. There's fibrosis that is occurring.
13 There is a process that is occurring, but I wouldn't call that
14 process a disease until it's diagnosed as a disease.
15 Q. Doctor, can someone be sick and die in between here
16 before you see it, by having a disease process that happened
17 from exposure to asbestos, a latency period having fibrosis
18 occur in the lungs and you cannot see it here?
19 A. That wouldn't be very likely for someone to die from
20 asbestosis before we're able to clinically diagnose it, no.
21 Q. Doctor, I'd like to talk a little bit about your
22 background. If someone want to go through some of the medical
23 literature and see some of the articles that you have
24 published on asbestos, would we find any?
25 A. I have not published on asbestos.
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page 5858
1 Q. And tobacco?
2 A. I have not published on asbestos.
3 Q. And tobacco and asbestos interaction?
4 A. No.
5 Q. The jury has heard a lot about peer review articles here,
6 but you're not here today to talk about any peer review

articles that you have written on the subject?
A. I have not written any peer review articles on the subject.
Q. That would include any of your clinical experiences with asbestos, correct?
A. That's correct.
Q. You've never been part of the Surgeon General's panel of experts on smoking and health matters?
A. No, I have not.
Q. Any asbestos matters?
A. No. Not on the Surgeon General's reports, no.
Q. You're own university has smoking cessation programs?
A. My university currently does have smoking cessation programs.
Q. And has taken positions on smoking and health?
A. They have, over the course of time.
Q. And have you been consulted on any of those matters?
A. I have not been involved in any of those matters, no.
Q. I ask you that because, nevertheless, you've asked here,
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retained by the lawyers for the tobacco defendants here, and you will agree with me they didn't find you by going through the medical literature, correct?
A. That's correct.
Q. In fact, Mr. Schroeder, I believe, someone in his office asked your brother if he knew anyone who was in occupational medicine?
A. Well, I'm not sure how it transpired in terms of asking my brother, but I know that someone in his office was familiar with my brother, so when I received the phone call, they used my brother's name --
Q. There's nothing wrong with that.
A. -- to get me on the phone.
Q. Your brother referred you to the lawyers, and you're here today, correct?
A. Again, I'm not sure exactly how that referral transpired, but they certainly used my brother's name when I received the phone call.
Q. Doctor, you have published articles, have you not?
A. Yes.
Q. You published articles on some eye bank issues in Cornea Magazine?
A. Yes.
Q. You're not a B-reader?
A. No.
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Q. I think you said on direct yesterday, you're not -- you don't perform any ILO interpretations that a B-reader would?
A. A B-reader would perform those interpretations.
Q. You're not here to discuss any relationship between lung cancer and tobacco smoking or asbestos, right?
A. That's correct.
Q. Doctor, I want to talk about three things that you were asked to do while you were here. You were asked to review the literature, and you made some conclusions based on your review of the literature, correct?
A. That's correct.
Q. And review claim forms?
A. Yes, claim files.
Q. And review the TDP criteria, comment on that?
A. That's correct.

16 Q. Doctor, one of your sources for the medical literature
17 you reviewed was -- came from Mr. Schroeder's firm; is that
18 correct?
19 A. Mr. Schroeder's firm did send me a number of articles.
20 Predominantly, the source of my review, however, was my own
21 search that I conducted, as well as my own files.
22 Q. Prior to your review of those articles, you did not think
23 you had conducted an exhaustive review for yourself to write
24 on the subject matters you're testifying here today to; is
25 that correct?
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page 5861
1 A. I would never write an article without prior -- no matter
2 how familiar I was with the field -- without immediate prior
3 research of the literature because that's the way one would
4 write a peer review type of article.
5 So prior to coming here today, I had not conducted an
6 exhaustive search such that I would sit down and write that
7 type of article, no.
8 Q. Do you feel like you've conducted that type of research
9 now today?
10 A. Yes, I do.
11 Q. Doctor, in your direct, you showed the jury a chart that
12 went through various other diseases that could inhibit
13 someone's impairment, correct?
14 A. I'm not sure which chart.
15 Q. The obesity chart?
16 A. The restrictions?
17 Q. Yes.
18 A. Okay.
19 Q. And I just want to make sure you didn't want to leave the
20 jury with an impression that there has not been a tremendous
21 amount of exposure in the United States to workers and
22 asbestos, correct?
23 A. There's been exposure to workers who have been exposed to
24 asbestos, absolutely.
25 Q. Doctor, you are familiar with the Surgeon General
page 5861
page 5862
1 reports?
2 A. Which one?
3 Q. The 1985?
4 A. Yes, I am.
5 Q. Doctor, in the beginning of the Surgeon General's
6 report --, can you see the screen in front of you there?
7 A. Maybe I need it a little bit closer.
8 Q. It details that this report will provide a detailed
9 review of the relationship between smoking and hazardous
10 substances in the workplace, and in particular, instructing
11 because of the added health burden that many workers carry if
12 they smoke cigarettes.
13 Do you agree with that statement there?
14 A. Well, there certainly is an added health burden of
15 smoking cigarettes, so I agree with that.
16 Q. And it goes on to say this report will make clear for
17 some workers this added burden is substantial. Correct?
18 A. Okay.
19 Q. Does it say that?
20 A. Yes, it says that.
21 Q. No better example exists to illustrate this interaction
22 than that of the asbestos workers.
23 A. That's what it says.
24 Q. Okay. You agree that letter is to the former President

25 Bush that appeared in front of the Surgeon General's report?
page 5862
page 5863
1 A. That's what it says.
2 Q. Doctor, I just want to bring it to your attention just so
3 we understand some of the magnitude of what we are dealing
4 with here today.
5 The report says at page 201, the number of workers
6 exposed to asbestos in the United States has been variously
7 calculated, but a detailed review by Nicholson and colleagues,
8 1982, estimated that 18.8 million workers have had more than
9 two months of exposure in occupations where significant
10 asbestos exposure are may have occurred.
11 A. It says that.
12 Q. Have you read that statement before?
13 A. I have read that statement before. There are a number of
14 different numbers that come up, but I wouldn't have any way of
15 knowing which one was more accurate.
16 Q. Doctor, you wouldn't be here today to suggest that the
17 Manville Trust is not getting a significant number of people
18 who have been exposed to asbestos, who have been injured by
19 asbestos, and do have disease from asbestos, you don't want to
20 suggest that with your charts yesterday?
21 A. I'm not suggesting that the Manville Trust wouldn't see
22 people who are diseased from asbestos, no.
23 Q. And you told us yesterday you yourself still see two to
24 three patients a week as a result of asbestos-related
25 diseases?
page 5863
page 5864
1 A. I see two to three patients a week for asbestos
2 surveillance. Not all of them have asbestos-related
3 diseases.
4 Q. How many a year?
5 A. That would be a hundred to a one hundred and fifty
6 medical surveillance examinations that I'm doing per year for
7 asbestos, as well as disability type evaluations. So a number
8 of them are ill, but not all of them.
9 Q. Doctor, you will agree with me that, unfortunately, a lot
10 cannot be done today for those people exposed to asbestos,
11 correct?
12 A. That's correct. Unfortunately.
13 Q. The asbestos fibers stay your lungs?
14 A. Asbestos fibers are not -- not all of them are retained
15 in the lungs, but there certainly is problematic that a number
16 of them can be retained in the lungs.
17 Q. There is no way to get them out of your lungs once they
18 are there?
19 A. Some asbestos fibers are exhaled and are released from
20 the lungs. Usually that is something that occurs pretty much
21 right away. Once they been lodged in the lungs, for the most
22 part, not completely, but for the most part they stay.
23 Q. One of the ways you get it out of your lungs is your
24 clearance mechanisms are working correctly, right?
25 A. That's one mechanism that they do get out of the lungs
page 5864
page 5865
1 by.
2 Q. Would you agree with me, Doctor, that with people who do
3 have asbestos fibers lodged in their lungs, the best thing
4 thick that they can do is quit smoking?
5 A. I always recommend to my patients who are exposed to
6 asbestos, absolutely, that that they should quit smoking.

Q. Even if it's prior exposure to asbestosis, quit today?
A. Any exposure -- all of my patients any way, I tell them to quit smoking. But my patients who are exposed to asbestos, I usually discuss with them about quitting smoking, yes.
Q. Even today there is still opportunity for exposure to asbestos, you will agree with me?
A. Yes.
Q. Are you familiar with Dr. Levin?
A. Yes, I am.
Q. Do you know where Dr. Levin practices?
A. At Mt. Sinai.
Q. You testified a little yesterday talking about some of the -- we have OSHA and some regulations in place, but Dr. Levin -- I will give you the title. Medical Examination for Asbestos-related Disease -- put out in July 1999, published in this year 2000 -- last year now.
There are millions of workers whose exposure to asbestos dust prior to the implementation of asbestos, regulation and improved control measures places them at risk

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of asbestos-related disease today.
We just touched on that, didn't we?
A. Yes.
Q. In addition, workers are still being exposed to significant amounts of asbestos when asbestos materials in place are disturbed during renovation, repair, or demolition.
Given the continued presence of asbestos-containing materials in industrial, commercial and residential settings throughout the U.S., a sizable population remains at risk of asbestos-related disease.
Do you agree with that, Doctor?
A. I agree. I think the population is decreasing over time, but there is still considerable opportunity to be exposed to asbestos.
Q. Doctor, will you agree with me that 70 to 80 percent and sometimes up as high as 90 percent of asbestos workers are smokers?
A. That was a big range that you gave me. I think 70 to 90 percent and --
Q. There has been different ranges, 80 to 90 percent usually --
A. More typically I would see numbers around 80 percent in some of the insulation studies. I don't know what type of rate would be outside of those kind of heavily exposed insulators.

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So, for example, the Manville Trust has a very different population. I wouldn't really know the smoking rate in that group of people.
Q. Are you aware that a trustee testified here today that 80 to 90 percent of the Manville claimants also are smokers?
A. I'm not aware of that, no.
Q. Do you have any reason to disagree with that?
A. I have no reason to agree or disagree.
Q. Okay.
Doctor, yesterday you talked a little bit about latency, you require 15 years. You will agree with me that there's literature showing disease at less than fifteen years?
A. There's literature showing disease at less than fifteen years in a very heavy exposed population. So not in a population that we would see today, but in a population of

16 workers that you would have seen many years ago, yes.
17 Q. Would you have any disagreement with Dr. Burns, who
18 testified earlier in this trial and said that a 10-year
19 latency period was reasonable for the Trust to use?
20 A. I wouldn't recommend utilizing a 10-year latency period,
21 not for today's workers, especially for proceeding into the
22 future, because workers right now are exposed to much lower
23 amounts of asbestos, and if you're going to use a latency
24 period like ten years, you're going to be picking up -- you're
25 going to call something asbestos-related disease that may not
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1 be asbestos-related disease.
2 I have less concern about that 10-year latency period
3 in the past with a very heavily exposed population. My
4 findings with the Trust were that it wasn't that kind of heavy
5 insulator type of exposure, so I'm a little hesitant to use a
6 ten-year period.
7 Q. Did you see any latency problems at all in any of the
8 files that you reviewed?
9 A. I didn't really have an issue with the latency period.
10 Actually, most much them were fifteen years or greater
11 typically that I reviewed. My concern would be more for
12 future claims than what I have reviewed.
13 Q. I want to spend time on what you came here to discussion
14 about the ATS compared to the TDP and get some of your views
15 on that.
16 A. Okay.
17 Q. Doctor, I think you reviewed documents on both the ATS
18 and the TDP to go over criteria, correct?
19 A. That's correct.
20 Q. Would you agree with me that the TDP criteria is designed
21 to pay claims of asbestos-diseased persons?
22 A. That's my understanding. It's supposed to pay for
23 asbestos-related disease, yes.
24 Q. That says payment of claims. The ATS is a statement
25 devised to be used by physicians in a clinical diagnosis of
page 5868
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1 asbestos-related disease; correct?
2 A. ATS is for the purpose of physicians to diagnose disease,
3 yes.
4 Q. There's a similarity but a little difference in the
5 criteria there, correct?
6 A. Well, I don't know that I can comment on the TDP criteria
7 as if it were -- if the purpose of it were diagnosing
8 disease. I don't see why that would differ from ATS
9 criteria.
10 Q. You'll agree with me the criteria is designed to pay the
11 claims of asbestos-diseased persons, correct?
12 A. By diagnosing disease is what you have mentioned.
13 Q. Injured by asbestos?
14 A. Well, insofar as if the TDP criteria is to make payments
15 for diagnosis of disease for people who have become sick from
16 asbestos, then it would make sense for it to use guidelines
17 that a physician would use for diagnosis.
18 Q. Can you be injured from asbestos and still not have a
19 clinical diagnosis, Doctor?
20 A. You can have pathology -- you can have changes in your
21 lungs. You can have fibrosis that is occurring and you're not
22 sick from it yet, yes.
23 Q. You can be injured and yet not clinically diagnosed?
24 A. You can have lung fibrosis, that type of thing, I guess

it depends on what injury means, but not clinical illness.
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Q. And you are aware that the TDP is paying for a person injured or damaged by their exposure to asbestos?
A. I'm not really aware of the TDP in terms of what they have spent is, but I thought it was to pay for someone who was clinically diseased, that's what I thought it should be --
Q. Doctor, you spent a lot of time going through a lot of TDP documents?
A. Yes, I have.
Q. And it's your belief that the Trust shouldn't pay anyone unless they have a clinically-diagnosed disease?
A. I wouldn't say who the Trust should and shouldn't pay for. It would make sense to me as a physician if I had limited funds to pay people who are sick, who have a disease process and are ill, as opposed to paying for changes in a chest x-ray that may or may not affect the individual.
Q. But you don't know --
A. I can't tell you what they were thinking in terms of payment.
Q. You can't tell me for compensation purposes whether the injuries here account for damage to a person versus -- even though they don't have a clinical diagnosis?
A. I mean, as a clinician, that's what I'm looking for. I'm looking to see whether lung, you know, x-ray findings, pulmonary function findings, whether the process of fibrosis eventually leads to impairment. So I would really be looking
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at the impairment part.
Q. You're not here to tell us about compensation, who should be compensated, who should not be?
A. No.
Q. How you value people who are injured by asbestos?
A. That's not my role.
Q. You went on little bit yesterday about the scarring process of asbestosis, scars in lungs, causes of fibrosis?
A. Yes.
Q. Again, that's occurring during this period of time, correct?
A. Well, it begins to occur during that period of time.
Q. You have the exposure and, as we established, 80, 90 percent of people smoking during the exposure, the latency period, the fibrosis occurring there.
Doctor, asbestosis is a progressive disease?
A. Well, the initial part of your statement I don't know if I'm answering that as to the smoke rate, that I can't comment ton. The question that you -- the latter question in terms of asbestosis being a progressive disease, yes, it tends to be a progressive disease. It is not reversible.
Q. As you get here, it just keeps getting worse, can cause death, but sometimes just causes --
A. It doesn't always continue to progress either. That's something that is difficult to determine who will progress and
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who won't, but it certainly doesn't improve.
Q. Doctor, we have spent a lot of time on talking about restrictive disease. We're going to talk about that, but I just wanted to touch on the ATS criteria on that.
Doctor, will you agree with me that the ATS in their clinical findings talks about the restrictive nature of the

disease in an advanced stage?
A. They say in advanced stages, asbestosis is a restrictive lung disease associated with, and they go on to discuss all of the different symptoms.
Q. You have to be pretty down on that chart, clinical stages, and even advanced clinical, to start the restrictive patterns; is that correct?
A. No, I wouldn't say that they are talking about advanced stages, they are talking about the dyspnea that occurs, the clubbing of the fingers. Clubbing of the fingers occurs when someone doesn't get enough oxygen to their system.
In other words, to get curving of the fingernails, that is a very advanced stage of the disease. I don't think they are saying the restrictive part of is advanced.
You may have a mild restrictive defect. I think the advance part is all of the other symptoms they are listing to go along with that.
Q. Doctor, it says in advanced stages asbestosis is a restrictive lung disease?

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A. Associated with dyspnea, clubbing of the fingers, basilar crackles and widespread irregular opacifications on chest x-ray. So I think the statement is all inclusive.
Q. In advanced stages, one has restrictive shortness of breath, clubbing of the fingers, the crackles, and then the opacifications, and you refer to the advance stages when you get --
A. Even beyond the initial clinical, certainly.
Q. Okay.
Doctor, you are of the opinion that asbestos-related diseases are dose response, have a dose response?
A. Asbestos-related diseases have a dose response relationship to asbestos exposure.
Q. That means the more asbestos you get in your lungs the more likely you will get disease?
A. Yes.
Q. Doctor, I'd like to talk a little bit about the comparison of the ATS and the TDP. Doctor, are you a member of the ATS?
A. No, I am not.
Q. So the jury has a clear understanding of what the ATS standard is, can you tell us a little bit about that.
A. The American Thoracic Society. It would be one of the kind of societies that pulmanologists, for example, belong to.
Q. And there are other criteria one can use for diagnosing

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asbestos-related diseases?
A. There are other criteria, but I don't see that as probably the most accepted criteria, yes.
Q. Doctor, you will agree with me in the ATS -- this is in the summary section, the end of the four, five page document going through everything about the asbestos disease and clinical process -- they come to a summary on exactly what we should do.
They say in the absence of pathological examinations of the lung and the tissue -- that would mean actually examining the tissue for fibers?
A. Yes. That would mean either autopsy or biopsy of lung tissue.
Q. Would you recommend the Trust to do that in order to make sure their claimant had asbestosis, to get lung biopsy?

A. That would be very invasive. I would absolutely not recommend for the Trust to do that.
Q. All right. The diagnosis of asbestosis is a judgment based on a careful consideration of all relevant clinical findings.
You will agree with that?
A. Yes, I do.
Q. They list two necessary items, correct?
A. That's correct.
Q. They talk about a history of exposure?

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A. Yes.
Q. And that would go to the top, we go back and find out the initial exposures. Then they go, an appropriate time interval between exposure and detection.
Is that what we call the latency period?
A. That's the latency period. And the text recommended latency's fifteen years.
Q. That's what they would be, the two necessary findings are exposure -- one there, it's a necessary finding. Then they have to have the latency, correct?
A. That is correct. Those things in and of themselves wouldn't make a diagnosis, but they would be the first two requirements, not the only actual, absolute requirements.
Q. Before you could ever diagnosis someone with asbestosis, you have to make sure they are exposed to asbestos?
A. Exactly.
Q. You testified an actual cause of asbestosis is --
A. Asbestos.
Q. It's named after that. Okay. Then you have the latency period because it needs to scar the lungs and turn it into fibrosis process?
A. It does take time for that process to occur.
Q. Then, Doctor, we have the following clinical criteria is a recognized value, correct?
A. That's correct.

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Q. And these are some of the things you talked about yesterday. You will agree with me, not all of them are required?
A. It does not say that -- it does not require that each of those things be present.
Q. The ATS even states, you could have disease without having any of these?
A. You just have to show me where it states that.
Q. I'm not sure if you showed this to the jury yesterday. I am going to show them what the document is that we are talking about here. It is The Diagnoses of Nonmalignant Diseases Related to Asbestos.
We call it non-malignant because it's not a cancer; is that correct?
A. Yes.
THE COURT: Has that been marked or offered in some way.
MS. KEARSE: I will mark that, your Honor, as N2.
Q. The official statement of the American Thoracic Society was adopted by the ATS board of directors on March 1986. Okay?
A. Okay.
Q. I will show you the section we were reading from.
THE COURT: This is the summary at the end?

MS. KEARSE: Of the ATS document, your Honor.

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THE COURT: Yes.

Q. This document has focused on clinically detectable interstitial fibrosis due to asbestos -- an interstitial is fibrosis, when we talked about the bilateral interstitial disease?

A. That refers to that scarring process that occurs with asbestosis.

Q. Okay. The interstitial disease?

A. That's how the Trust seems to refer to asbestosis.

Q. Interstitial fibrosis due to asbestos exposure. While direct examination of lung tissue is the most reliable method of diagnosis, as stated above, this is rarely indicated in the assessment of workers for compensation purposes. Open lung biopsy is indicated in our opinion only when a clear health, rather than a financial, benefit is likely to be provided.

In the absence of pathologic examination of lung tissue, the diagnosis of asbestosis is a judgment based on a careful consideration of all relevant clinical findings.

We just talked about those findings right there.

A. Yes.

Q. Of these, the findings on the chest --

A. You can say X-ray.

Q. X-ray?

A. Roentgenogram.

Q. -- are the most important. When this criteria is not

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met, considerable caution is warranted. The specificity of the above criteria increases with increasing numbers of positive criteria.

Would you agree with me, the more positive criteria in the recognized value the more sure you are that you have asbestosis?

A. Yes.

Q. As in all clinical judgments, confounding variables, such as the presence of other clinical conditions that affect these criteria, should be evaluated. Correct?

A. That I agree with.

Q. It is possible that interstitial fibrosis may be present even though none of these criteria are established, but in our opinion, in these circumstances, the clinical diagnosis cannot be made.

Correct?

A. Yes. What that is saying is that interstitial fibrosis, the scarring, may exist, but it is impossible to diagnose it.

Q. Right. You could still have disease?

A. I wouldn't call it disease at that point. I would say --

Q. You may have interstitial fibrosis?

A. You can have the fibrotic process occurring, but in my opinion it is not yet clinical disease.

Q. Doctor, we're going to be talking about some of these -- you're aware of some of the authors of the ATS?

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A. Yes.

Q. Do you know any of these people?

A. I have heard some of the names. I don't personally know any of those people.

(Continued next page)

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EXAMINATION CONTINUES
BY MS. KEARSE:
Q. Doctor, do you follow the ATS's suggestion, clinical diagnosis, in the usual clinical setting the diagnosis of asbestosis has to be made in the absence of -- lung examination, we just talked about that. The benefit of doubt should be given whenever the clinical features and occupational exposure data are compatible with the diagnosis.
A. I have mixed feelings about that one. As a physician, when somebody -- when I am not certain that somebody has clinical disease, I hate to give them a disease. Because I think it has psychological effects, can actually be adverse and can make the person feel even sicker. So that part of it is a difficult thing to do.

On the other hand, for compensation purposes, if the person will somehow get a Workers Compensation benefit or something like that, I certainly want to make sure that if somebody is -- does have a disease process that I feel is related to asbestos, that I report it accordingly.

Q. Thank you.

ATS recognizes that when many or all of these features are present the diagnosis is made without difficulty. You will agree with that?
A. That's correct.
Q. The history, latency, and all four of those you could
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check off, it's -- you are sure beyond a reasonable doubt, that there is disease there?
A. I would have to see each circumstance, but then it becomes clear.
Q. However, in the absence of doing the lung tissue, the diagnosis is always inferential, correct?
A. It's an inferential process but can become -- it can become very clear with appropriate clinical skills and laboratory evaluation.
Q. Doctor, part of that is saying, you may -- you may find one person has disease and someone goes to another doctor and they may not have disease or vice-versa, you may not find it and they may go find it, and fine disease?
A. I think that typically you are going to find some level of consistency among doctors. Certainly when the -- when

asbestosis, when it is clearly clinical disease, and when it's severe, actually when it's clearly severe clinical disease. If you have minimal asbestosis you might find some doctors will vary on their diagnosis.
Q. Doctor, did you disagree with the doctor's notes that were in the files?
A. For the most part when I had clinician's notes that were in the files, the one who actually evaluated the patient and diagnosed asbestosis, not always but for the most part I agreed with those. The problem is there weren't a tremendous
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number of them. I don't know that I agreed all of the time.
Q. Your testimony is when there is --
MR. SCHROEDER: Excuse me.
THE COURT: Allow the witness to finish.
A. I can't tell you that I agreed every single time a clinician did conduct a history and physical and then made a diagnosis that I agreed with it, but I -- certainly I lend tremendous credence to that when I was reviewing the files.
THE COURT: The witness, if she will just answer the question succinctly --
THE WITNESS: Okay.
THE COURT: -- we will move things better.
Q. Doctor, would that include if a doctor diagnosed someone with asbestosis in a BID, a non-disabling BID and diagnosed him as asbestosis, is it your testimony that you agreed with their diagnosis, that they had asbestosis?
A. When I reviewed the claims files, I don't think that any of the ones that were non-disabling that I actually made a diagnosis of asbestosis. Typically, either it didn't appear to be asbestosis or there just wasn't enough information.
Q. You are --
A. Most of them also did not include clinical information.
Q. Doctor, that was in your opinion?
A. In my opinion, yes.
Q. Even when there was a doctor's letter in there, stating
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they did have asbestosis, a non-disabling asbestosis?
A. It was very infrequent that there was a doctor's letter other than a radiologist.
Q. We are going to get to some of the claims a little bit.
Doctor, yesterday one of your main, I think, disagreements with the Trust criteria is one slash zero criteria, is that correct?
A. Well, utilizing a one slash O without other information, yes.
Q. A one slash zero, again for the jury, is looking at the X-rays, where a B-reader would compare one X-ray to a standard ILO, standard International Labor Organization standard, they compare X-rays?
A. That's correct.
Q. Okay. And they see whether or not there is disease on it and one --
A. They see whether or not there is fibrosis on it.
Q. Okay. One slash zero means a B-reader reviewing the film saw fibrosis; is that correct?
A. They reported it as slight fibrosis with the possibility, with severe -- with consideration. Serious consideration I think is how it is phrased, that there is -- a normal film.
Q. Doctor, you will agree with me that the ATS does not require a one slash one?

25 A. ATS, basically, the way it is stated, it is not up there
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1 anymore, is that they lend credence or something to that
2 effect.
3 Q. They talk about a one slash one being of a recognized
4 value?
5 A. That's correct.
6 Q. Under the ATS it is not a requirement to have a one slash
7 one?
8 A. No, it is not.
9 Q. It is a recognized value, you have a one slash one, you
10 are saying B-reader one sees one, and he assumes the next
11 person will see it, right?
12 A. I'm sorry. Say that again.
13 Q. A one slash one would mean the B-reader who is reading
14 the X-ray sees a profusion level of one and grades it as
15 another one because he thinks the other reader will see it as
16 a one, is that correct?
17 A. Not exactly. I think the way ILO says is that he reads
18 it as that it has some slight changes and that's what
19 he -- didn't give serious consideration to other -- to other
20 possibilities, that that's what he thought it was.
21 Q. Doctor, I think you were shown a document yesterday that
22 said the only reason the Trust is usually one slash zero is to
23 settle claims.
24 A. I don't recall.
25 Q. Do you remember seeing that?
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1 A. I don't recall saying they are using it just to
2 settle -- for the purpose of settling claims. But utilizing
3 one slash zero is not something I would recommend without
4 other clinical information.
5 Q. Okay. With other clinical information, is there anything
6 wrong with a one slash zero?
7 A. There are sometimes with a one slash zero, if I have all
8 of the other important clinical information, that I can make a
9 diagnosis of asbestos related disease but I would need to have
10 pretty convincing evidence otherwise.
11 Q. Doctor, I would like to talk a little bit about the one
12 slash zero. Again, you are not a B-reader. You send your
13 X-rays to a B-reader to have read?
14 A. Yes, I do.
15 Q. Okay. If someone does come to you with a one slash zero,
16 have you diagnosed patients with asbestosis?
17 A. I have on rare occasions, yes.
18 Q. But you agree with me that there are prominent members of
19 the profession that agree that a one slash zero means
20 asbestosis?
21 A. I think everyone agrees that a one slash zero means that
22 there is fibrosis, that the reader meant it to read as that
23 slight fibrosis with serious consideration that there was
24 a -- there was not any evidence of fibrosis, they would take
25 it for what it is.
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1 Q. You didn't want to leave the impression with the jury
2 that the TDP's acceptance of a one slash zero is unreasonable,
3 is it?
4 A. I think that real issue I have is that there wasn't the
5 requirement for other clinical information as well, that the
6 chest X-rays stood alone to make a diagnosis.

Q. You will agree with me that chest X-ray is one of the most important things in the ATS?
A. Yes.
Q. You have the most -- you have the necessary history, latency and the X-ray, correct?
A. Those would be the two -- the two are absolute criteria and the chest X-ray would be one of the most important things, yes.
Q. Doctor, would you agree with me in your review of the medical literature that there is an abundance of literature out there that shows the profusion levels of one slash zero or greater have shown fibrosis and opacities in the lungs?
Are you familiar with some of these studies?
A. I am familiar with some of these studies. There certainly is literature out there that shows levels of one zero, in correlating the process, has fibrosis of the lungs. There also -- the correlation isn't real strong. It becomes much stronger as the levels of profusion increase.
Q. You will agree with me even in -- into 1983, the ILO

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there in Geneva, who is responsible for the 1980 ILO readings, correct?
A. I see.
Q. Established it. That they state that diagnosis of asbestosis depends upon, one of the things is the radiological features consistent with basal fibrosis and they call it category one slash zero and over. ILO 80.
A. That's what that says on the slide.
Q. Okay. Again, in 1987, Bohlig, pulmonary fibrosis, small opacities of profusion one slash zero or more.
A. Again, that's what that says there.
Q. The next one, please.
Do you have any reason to disagree with others in the field using the one slash zero to either study disease in the field for asbestos workers that have disease as the one slash zero?
A. Very frequently, for the purpose of research, a cutoff of one slash zero is utilized. That's not necessarily the recommendation of even those researchers in terms of clinical diagnosis. So there is a little bit of a difference between what research may use and what is utilized for clinical diagnosis.
Q. Doctor, will you agree with me when they are doing these research studies for disease at a one slash zero, they are looking for disease, correct?

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A. What they are actually -- they are actually not looking for disease because they are only looking at chest X-rays. What they are looking is for chest X-ray findings of fibrosis.
Q. And that relates to the population who has been exposed to asbestos and seeing what the changes are occurring from exposure to clinical diagnosis and they recognize a one slash zero to be of value in evaluating these people?
A. For research purposes, they are using a one slash zero to indicate the beginning levels of fibrosis.
Q. They would do that because, obviously, that has some concern over an -- in a worker having a one slash zero reading, correct?
A. I don't know that you could extrapolate that from those studies.

Q. This doctor -- you agree with me, they are studying populations of asbestos exposed workers?
A. That's exactly right, looking at population based studies and utilizing a one slash zero for that purpose.
Q. They are finding abnormalities, let's go to Barnhart, 1988. The findings in our evaluation predominant ILO one slash zero profusion abnormalities is consistent with those of other standards.
They are saying there is abnormality in the lung at a one slash zero, correct?

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A. That's what that says right there.
THE COURT: Is this already in evidence?
MS. KEARSE: Yes. I am going to mark these.
MR. SCHROEDER: I would object to the slide. Those are snippets from studies. I think the -- what we are doing is if they have studies and they want to show the studies, at least I would like the relevant portions that --
THE COURT: We will put them in. You can move to strike if the studies are not made available.
MR. SCHROEDER: All right.
MS. KEARSE: I have all the studies. We will provide a list at the end of the testimony with those.
Q. Doctor, the ILO is the organization that we talk about doing the one slash one and one slash zero's?
A. Yes.
Q. Okay. I want to show -- we will mark this as M-3. The Encyclopedia of Occupational Health and Safety. If we can read it. By International Labor Office in Geneva. It is dated 1983. Three years after they put the standards out for the ILO's.
Doctor, have you seen this document before?
A. This is coming out of the 1983 textbook? There is a much more recent one, but okay.
Q. Will you agree with me in the asbestosis section we have a summary of diagnosis?

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A. I agree that there is a summary of diagnosis there.
Q. Okay. And the diagnosis of asbestosis therefore depends on a history of significant exposure to asbestos dust rarely starting less than ten years.
They say, you know, ten years you may have something. It's rarely before ten years but they -- they use a ten-year latency there, correct?
A. That's what the old textbook utilizes. I am not even sure what the current one would utilize.
Q. The one I have is the '83 one. We can compare that. This is the one I have.
Okay. B, the radiological features consistent with basal fibrosis of a one slash zero and over, ILO 1980.
A. That's what it says there.
Q. Doctor, do you know Doctor Weill?
A. I know the name and some of his research.
Q. Do you recall seeing his name on the list of authors of the ATS?
A. Yes.
Q. The jury may have seen this before. Doctor Weill made -- he wrote, the diagnosis of asbestos related disease a year after the standards went out in '86. This is 1987.
He states, for one reader this benefit will be more or less equivalent to and ILO reading of one slash one for

irregular small opacities.
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When we talk about the opacities, are we talking about the fibrosis?
A. Yes.
Q. Process? Okay.
I am not sure, can you explain what opacities are? Can you spend a second just to explain what the opacities are?
A. Sure.
Opacities is what you would see on the chest X-ray. What they reflect is actually the fibrosis that occurs, the scarring that occurs shows up on an X-ray as small opacities. They tend to be irregular with asbestos exposure.
Q. One way you tell about the asbestos exposure is that they are irregular versus some other exposures, the opacities would be round?
A. That is correct.
Q. Doctor, would you agree Hans Weill stated that it's unfortunate that some readers have interpreted the ATS, with everybody talking about, to suggest that a reading of at least a one slash one for small opacities is required to support a diagnosis of asbestosis?
Correct?
A. That's what it says, yes.
Q. Do you agree with Mr. Weill -- Doctor Weill?
A. I agree that you should not exclude somebody who has a film level one zero if they have other evidence of
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asbestosis.
Q. Did you find in any of your reviews of the claim files, did you find any one of the one slash zero to have asbestosis?
A. No, I did not. They didn't have other sufficient evidence of disease.
Q. Would you have any reason to disagree with Doctor Selikoff also finding that the lowest positive reading could be a one slash zero?
A. Again, a one slash zero is exactly how it is defined. It is read as slight fibrosis with serious consideration that non-exists.
Q. So you agree with me then we could have a one slash zero and you want more information on that before you would diagnosis someone with asbestosis, correct?
A. Yes.
Q. All right. You also had some other criteria that dealt with the shortness of breath. We talked about the crackles and the rales, correct?
A. That's correct.
Q. Do you require everyone to have crackles and rales?
A. No.
Q. I probably sound like I have a lot of rales in my throat here, but the crackles, you will listen to them and they sound like cellophane when you are listening to them?
A. Yes.
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Q. Okay. How many of your patients that you have diagnosed with asbestos related diseases have crackles and the rales?
A. Probably just under 50 percent.
Q. You would agree with me that you could have asbestosis or asbestos related disease without the crackles and without the rales?

A. Yes.
Q. And without the clubbing?
A. Yes.
Q. They may be far more advanced stages where you'd see some of those?
A. Yes.
Q. Doctor, pleural plaques, where on this would you find pleural plaques?
Would that be a clinical diagnosis?
A. Pleural plaques is -- that's a chest X-ray finding. I don't say it is a clinical diagnosis of disease, no.
Q. Is it a marker?
A. It's utilized as a marker for asbestos exposure at times.
Q. If you find a one slash zero with pleural plaques, are you -- does it give you any more assurance that you have an asbestos related injury?
A. Well, the pleural plaques is separate from the pleural fibrosis so it gives you a little more assurance that's

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asbestos exposure that may be the result of your one slash zero. So it helps a little bit. But they are two separate processes. So it really doesn't aid in the diagnosis of asbestosis.
Q. It is kind of like a signature? If you have a pleural plaque and you have a history of exposure and latency, and you've got pleural plaques in your X-ray with the reading, it is kind of a signature that it is asbestos related?
A. It is a marker that there has been asbestos exposure.
Q. Did you see in your review of the files claims with pleural plaques?
A. Yes.
Q. Did you diagnosis any of those with asbestos related diseases?
A. I would think that some of the chest X-rays that had pleural plaques eventually ended up with diagnosis of asbestosis. But it would be based on other things, not the pleural plaques.
Q. Did you diagnosis anyone with asbestosis if they had -- if they didn't have impairment?
A. If they did not have impairment? Well, I was really looking for an impairment. That's the way I would diagnosis clinical disease.
Q. Is that one of your main criteria, that you look for yourself, as impairment?

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A. Impairment, meaning symptoms, like shortness of breath or pulmonary function findings.
Q. You will agree with me that's on the recognized value section of the ATS?
A. That's correct.
Q. Doctor, I want to spend a little bit just about what we were talking here, about some of the clinical disease process.
A. Okay.
Q. Are you familiar with the literature that there is disease and actual asbestosis in this area here?
A. Within that range, I would really call it a -- like a fibrotic process. I wouldn't really call it disease until it is diagnosed as clinical disease.
MS. KEARSE: Could I have chart 14, please?

16 Q. Doctor, are you familiar with some of the studies that
17 have looked at populations of asbestos exposed workers and
18 have shown that upon reviewing the lungs, a lot of times these
19 are on autopsy, that there were percentages of normal
20 findings, so it would be non-clinical yet, and yet there was
21 disease, and I will start with Doctor Epler, 1978.
22 One out of 458 parents with such disorders chronic
23 diffuse infiltrative lung diseases histologically -- is that
24 looking at the lung tissue?
25 A. That's correct.
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1 Q. Okay. Confirmed, forty-four or nine point six percent
2 had normal prebiopsy films.
3 A. That's what it says.
4 Q. Liddell in 1980 -- do you know who Doctor Liddell is?
5 A. I am familiar with some of his research.
6 Q. He actually was one of the prime people involved in the
7 ILO in 1980, of actually setting out the twelve point
8 standards?
9 A. Yes.
10 Q. Okay. He found that parenchymal, which would be lung
11 changes, had been recorded in 23 of 31 deaths so coded but
12 five were normal.
13 A. That's what that little piece of information says.
14 Q. Doctor Kipen in 1987, a negative chest radiograph does
15 not exclude the presence of interstitial fibrosis or
16 asbestosis in a substantial proportion of insulation workers
17 who previously were exposed to asbestos who develop lung
18 cancer.
19 A. Again, that's what it says.
20 Q. You agree with me, doctor, you could have the
21 injury -- interstitial fibrosis, only diagnosable in a
22 clinical setting, after you looked at the tissue on autopsy?
23 A. You can have fibrosis on autopsy that has not been
24 detected by radiology, yes.
25 (Continued on the next page.)
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1 BY MS. KEARSE:
2 Q. And it could actually be a cause of death to have the
3 fibrosis and asbestosis even though you never had any clinical
4 symptoms to it?
5 A. Not typically. Typically, if asbestosis is the cause of
6 death you do have clinical symptoms.
7 Q. Doctor, do you recall reviewing one of the claims where
8 only on autopsy did you find a reading of asbestosis?
9 A. Say that again.
10 Q. Do you remember reviewing the records of Joseph Slusser?
11 A. I don't really recall the names.
12 Q. You reviewed the files and made notes?
13 A. That looks like some of my scribbles.
14 Q. And for this gentleman do you recall that reviewing the
15 file of Mr. Slusser?
16 A. I wouldn't really recall his exact file. Those are
17 certainly my notes. If you want to provide me with the file,
18 that would help.
19 MS. KEARSE: May I approach, your Honor?
20 THE COURT: Yes.
21 Q. Now, doctor, --
22 THE COURT: Is that being marked separately? Are
23 you going to mark all these at the end?
24 MS. KEARSE: M 4.

25 Q. Doctor, is this one of the BID claims, that's the
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1 non-disabling claims, and is this typical of your notes, you
2 got the claims, did you review them at home or in your office?
3 A. I reviewed them at home. At times I just wrote down some
4 notes.
5 Q. You took notes and we have your notes. For this
6 gentleman this is the extent of your notes?
7 A. Okay.
8 Q. Okay.
9 And this gentleman would not have met your criteria,
10 correct?
11 A. Well, this gentleman had a diagnosis by autopsy. I
12 wouldn't do that. I would conduct a clinical evaluation.
13 This is not something that I would make a diagnosis on.
14 Q. But in your notes you did not -- you distinguished
15 everything, whether you were able to diagnose or not diagnose,
16 it would not have met your clinical diagnosis had you looked
17 at him, correct?
18 A. The information I have here is just my jottings with
19 which was an autopsy with interstitial fibrosis with asbestos
20 bodies. I have no idea in terms of pathology what level that
21 was. Just based on this information that I have in front of
22 me, I couldn't make a diagnosis, no.
23 Q. You have the file in front of you?
24 A. This is the file. Okay.
25 Q. Okay. You'll agree, if you'll look, Mr. Slusser had
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1 exposure? Do you see on page six of his claim?
2 A. Page six.
3 Q. The question on the claim form, all the claimants have to
4 fill out their exposure history?
5 A. Yes.
6 Q. Mr. Slusser says his most significant exposure to
7 Manville asbestos occurred from 1938 until 1985?
8 A. That's correct.
9 Q. That would give us both exposure and a latency period,
10 first exposure in 1938, is that correct?
11 A. That's correct.
12 Q. Doctor, we agree that the file indicates that he had
13 prior pleural plaques?
14 A. If you can point to where that is. I don't see any
15 medical records of that.
16 Q. I'll agree with you there's no ILO reading in that file.
17 A. Is there a chest x-ray in the file?
18 Q. Right.
19 I'm going to show you what's in the file. February
20 19, 1996. The letter talks about a review of records and
21 pathology materials. There was a radiology report of
22 bilateral pleural plaque formation.
23 I'll go to the second page.
24 These findings support my conclusion, to a reasonable
25 degree of medical certainty, that Mr. Slusser's occupational
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page 5900
1 asbestos exposure was the cause of his pulmonary asbestosis
2 and asbestos-related pleural plaques, and was a substantial
3 contributing factor to his death.
4 A. This file, if my recollection is correct, was purely
5 based upon pathology. So I hadn't made a diagnosis nor not
6 made a diagnosis. It was something where I felt that that

wasn't what I would clinically do.
Q. But you'll agree with me it was not until autopsy that they were able to find that he had asbestosis?
A. As opposed to prior? Well, there's no evidence of having undergone an evaluation, is there, prior to that?
Q. There's no evidence of having an ILO reading before that.
A. So I really wouldn't know whether, if he were evaluated prior to autopsy, I wouldn't know whether he would have been diagnosed or not.
Q. But he did file a claim for a non-disabling bilateral interstitial disease; right?
A. I'll agree if that's what you are telling me, sure.
Q. Doctor, I think you testified on direct, you spent a lot of time talking about impairment. It's your opinion that you have to have impairment in order to have disease?
A. Yes, that's my opinion.
Q. Have you seen literature where the confounding factors of smoking and having exposure to asbestos really impair one's

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ability to figure out what the impairment is or what the impairment is due to?
A. Would you tell me what literature that you are referring to?
Q. Okay.
Have you seen such literature discussing the variabilities of trying to assess someone's impairment when there are confounding factors of smoking involved?
A. Well, there's some discussion, certainly even the Surgeon General's report discussed impairment from smoking versus asbestos, for example, and trying to differentiate the two.
For the most part they concluded that they were pretty much independent, that they had independent changes. There may be times in very rare instances where it can be difficult.
Q. Will you agree with me that you can have x-ray readings of fibrosis without any impairment?
A. Yes.
Q. So one of the clinical things you can have here is you can have an x-ray reading of 1/0, 1/1, 1/2 and have disease process and yet not have impairment?
A. As you are getting up to 1/2 you are very likely to have impairments. Certainly at the lower levels, yes.
Q. You could have a lower level and have the process occurring of asbestosis or interstitial disease and not have

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impairment?
A. Yes.
Q. But you required impairment in all your reviews of the files?
A. Yes, I did.
Q. So you would agree then with Dr. Levin, again, at Mount Sinai, you might not agree with everything he is says, but he says some patterns with marked parenchymal abnormalities on x-ray may have no symptoms and have normal pulmonary-function?
A. Yes.
Q. Do you require impairment in everyone who comes to your office before you will diagnose them with an asbestos-related disease?
A. Everyone, that's strong. For the most part, I would require impairment.

Q. And you just told me with all the claims that you reviewed you actually looked for impairment there?
A. I looked for impairment. That's not to say if I had a chest x-ray of 3/3, or strong evidence, that the impairment might not be necessary. But very typically I require impairment.
Q. But you could have a lower level profusion. 1/0 or 1/1 but without the impairment yet?
A. Yes, you can.
Q. So you can have a clinical diagnosis and it would be

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reasonable for the Trust to accept that claim as a disease?
A. I wouldn't call that a clinical diagnosis, just based on a chest x-ray.
Q. You just said you could have the disease without the impairment, correct?
MR. SCHROEDER: Objection.
A. I thought what I said was you can have --
THE COURT: Excuse me.
Ask another question.
Q. Doctor, we've talked about the total lung capacities and you just mentioned the Surgeon General report would you agree with me --
THE COURT: This is from what?
MR. KEARSE: I'll mark this as M 5. This is a page -- I'm sorry. M 6.
Q. The presence of a lung injury secondary to one agent or process does not prevent the lung from being injured by a second agent.
So we're talking about being injured from smoking and also being injured by asbestos?
A. Two separate injuries, sure.
Q. In evaluating impairment in an asbestos-exposed smoker, it may be difficult to apportion the impairment between the two agents because both cigarette smoking and asbestos exposure may alter a given lung function test in the same

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direction, e.g., both of them will reduce the diffusing capacity or they may change a test in opposite directions, an increase in total lung capacity, the TLC, due to smoking may mask a decline in TLC due to asbestos.
I think we talked a little bit that in an obstruction the TLC will go up and in restriction it goes down?
A. That can happen.
Q. It's almost cancelling each other out and you're left with a DLCO?
A. Rarely can you not differentiate between the two situations. I think the Surgeon General's report goes on to state that typically you can identify it. On some few occasions it can be difficult.
Q. But we have established we've got 80 to 90 percent of our asbestos workers smoking; right?
A. That's correct.
Well, actually, I don't know that I ever -- that's what you have stated to me and it may be the case.
Q. Do you have any disagreement with the Surgeon General's report?
A. I don't agree or disagree. I don't know the numbers. I don't want to report something I don't know.
Q. We want to get out of the here. Right. Okay.
We mentioned earlier -- this is an article that I

have marked M 7, by Dr. Burns. Do you know Dr. Burns?
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A. I know his name. I know he's involved with the Surgeon General report.
Q. You know he testified here earlier in this trial?
A. Yes. I've been told that.
Q. Dr. Burns wrote in his article -- it's called Chest, TLC In Combined Restrictive and Obstructive Lung Disease.
Again, the obstruction can occur from smoking?
A. Obstruction, yes, typically occurs from smoking-related disease.
Q. Are you familiar with literature that talks about asbestos causing obstructive disease?
A. Well, there's some literature that shows possibilities of decline in FEV 1 over FEC ratio. For the most part, the literature does not show that.
Q. There are researchers who have concluded that asbestos can contribute to obstructive disease?
A. I think for the most part the Surgeon General as well as most researchers indicate that asbestos does not cause obstructive-related disease although there are a few studies that indicate that. But those would actually be the exception, not the rule.
Q. Let me tell you what Dr. Burns has to say.
He's talking about obstruction and restriction disease: Because these two processes affect the TLC in opposite directions, the TLC becomes a poor measure of the
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extent of disease and an insensitive measure of the presence of disease when lung injury is due to the combination of restrictive-disease process and an obstructive-disease process.
Would you agree with Dr. Burns?
A. Again, I agree with it. It rarely occurs. In my practice, it's very infrequent that I can't tell between a restrictive and an obstructive process. In the claims files it was a same thing, very infrequent.
Q. Doctor, you would agree with me the ATS addresses the difficulty sometimes when you have the tobacco-related disease of the obstructive process, an obstruction?
A. It may discuss that in there. The Surgeon General does as well, but I think the general consensus is that for the most part you can differentiate between the two disease processes.
Q. Doctor, I want to show you one of the articles that I was referring to when we talked about asbestos causing obstruction. Dr. Kilburn, do you know Dr. Kilburn?
A. He authored a couple of articles on asbestos that I have reviewed.
Q. And he talked about causing airway obstruction and asbestosis increases the airway obstruction?
A. That's what that one line says. Again, typically, the literature is showing asbestos not causing an obstructive
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process.
Q. Do you know a Dr. Rogli (ph.)?
A. I'm not certain. Can you give me context?
Q. Have you read the Pathology of Asbestos-Related Disease, Associated Diseases?
A. I have not read that text.

Q. You are not a pathologist?
A. I'm not a pathologist. That would be a pathology textbook.
Q. You never heard of Dr. Rogli?
A. I may have heard of him. He's not familiar.
Q. I want to tell you what Dr. Rogli reported in his book on asbestos.
THE COURT: What's the edition and pages?
MS. KEARSE: This is 1992, Pathology of Asbestos Associated Diseases, your Honor. I'll mark the page, page 82.
Q. There is also accumulating evidence that exposure to asbestos and a variety of other mineral dusts can contribute to chronic obstructive pulmonary disease.
Do you see that?
A. That's what it says.
Q. You disagree with Dr. Rogli?
A. The literature in general points to a restrictive process as opposed to an obstructive process.
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Q. Doctor, quickly, just about a couple of your claims. I want to review some of the your findings. You reviewed 74 claims out of 300,000 claims, correct?
A. 74 is definitely the number I reviewed.
Q. You didn't have time to review more than 74 claims?
A. I asked for some random sampling of claims files. I was given 74.
I could have reviewed a few more, not a few thousand.
Q. We're not here to judge the Trust on compensation, of what they value their claims as?
A. That's correct.
Q. You're here more for a clinical diagnosis from your own medical review on whether or not you thought, as a physician, that you could clinically diagnose someone with disease?
A. That's correct.
Q. Doctor, I could show you the things. If you'll take my word for it, you reviewed 27 BID claims?
A. Okay.
Q. Okay.
And 11 out of 27 of those claims, you lad a 1/1 or greater x-ray profusion?
A. Okay.
Q. And you did not diagnose any of those with asbestos-related disease?
A. Which means that there was not sufficient other evidence.
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Q. I'm going to review one quickly with you, doctor. You had a Mr. Collins?
A. May I have a copy?
Q. Surely.
Are those your notes from Mr. Collins?
A. Those are my notes.
THE COURT: Are you going to put this whole file in?
MS. KEARSE: Yes, your Honor. I'll mark that as M 8.
Q. Now, these are the extent of the notes I have here. But a review of the file would show Mr. Collins had an intense five year, 1942 to 1947, exposure?
A. Well, that would be included in medical information. That would just be in the proof of claims file.
Q. Did you use any of the information that was in the claim

form to help in your diagnosis?
A. I utilized primarily the medical information.
Q. So if someone put information in the claim form itself, you did not --
A. In terms of their exposure, like I pretty much assumed that the exposure existed, despite frequently there not being enough information about it or just information about what job category. If they said they smoked in it, that type of information I took. It didn't contain clinical information like symptoms or that type of thing.
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Q. Just quickly, doctor, Mr. Collins' file shows that he had significant exposure from 1942 to 1947 and he had a latency period of 42 years. And he had an x-ray.
A. All it says --
THE COURT: Excuse me. The question has not been asked.
THE WITNESS: I'm sorry.
Q. I'll try to review quickly with you. In his file that he filled out on the claim form or someone filled out for him?
A. I'm not sure I agree with that.
Q. You don't agree with that?
A. If we're looking at the same page, page 6, it says he worked from 1942 to 1947 in the chemical industry. That's all the information I have and that it's a circle saying directly in contact with asbestos. But there's no other information for me to assess whether the exposure was significant.
Q. But he does within his claim form talk about exposure, correct?
A. Yes, for a five-year period it says in the chemical industry. That's all the information.
Q. Okay.
In your experience, do you have any experience to know that there was significant exposures in the chemical industry for various time periods?
A. There may be.
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Q. And his x-ray gave him a 1/2?
A. That's correct.
Q. With pleural plaques, pleural thickening?
A. Yes.
Q. And a 1/2 gives you more comfort that there's disease?
A. A 1/12 would be a significant x-ray finding of fibrosis.
Q. There was no obstruction or restriction noted in the file?
A. The only medical information in the file was just a chest x-ray.
Q. Although he had the latency and exposure and a 1/2, and a 1/2 with pleural markers for asbestosis, you felt as a clinician you couldn't diagnose him with asbestosis?
A. There was certainly a latency. He may or may not have had the exposure. The only information I had was the chest x-ray. I wouldn't make that diagnosis with just a chest x-ray.
(Continued on next page.)

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THE COURT: You're not saying, as I understand your answer to this file, that it was unreasonable for the Trust, based on the information it had, to say that this was a reasonable diagnosis, are you?
THE WITNESS: No. What I'm saying is that I wouldn't be able to make a diagnosis with just a chest x-ray reading, as a clinician.
THE COURT: I don't understand the relevance of that to the question before us, the adequacy of these files to make a judgment with respect to the disease.
The Trust, you understand, is not treating. Do you understand that?
THE WITNESS: I understand that.
THE COURT: It's paying the claims.
THE WITNESS: Yes.
THE COURT: My questions have no significance here, ladies and gentlemen. I'm just trying to clarify the record.
BY MS. KEARSE:
Q. Doctor, I was trying to highlight some of the things that you did see in the claims when you were reviewing them, and I could go to more, but due to time we are going to move on from that.
A. Okay.
Q. Would you agree with me, also, that you did diagnosis some people that had no x-ray reading and you were able to
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diagnose them with asbestosis?
A. I don't recall -- perhaps if they had CAT-scans. Did they have radiology evidence? Typically, I was looking for radiology evidence. There may have been an example.
Q. I'm not going to go through all of them now, but do you remember Mr. Smith -- my question is, if you had no chest x-ray and you had someone come in your office with either a CAT-scan or without a CAT-scan, would you diagnosis anyone with asbestosis?
A. Certainly with CAT-scan I would. Without a chest x-ray, well, there would be no reason for my office to not obtain a chest x-ray.
Q. What if there was no x-ray in the file, but there was a doctor's note that talked about that they were diagnosed with asbestosis but didn't give you a profusion rating, would that give you comfort to diagnose someone with asbestosis?
A. If the x-ray indicated that there was bilateral interstitial lung disease.
Q. It would be a reason for the Trust to pay that claim?
A. I would require that it has to be an ILO.
Q. Doctor, I want to touch on one more thing, your statements about smoking does not aggravate asbestosis. You testified here yesterday -- Tuesday?
A. Smoking has not been shown to aggregate asbestosis.
Q. In your personal experience, is that upon your review of
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the literature or your personal experience?
A. Both.
Q. Are you aware of literature that talks about smoking, assisting in the abnormalities of fibrosis and actually turning up on the x-ray?
A. Smoking has been associated in the literature with

increased chest x-ray readings of fibrosis.
Q. And smoking and asbestos combined together, as has been in the literature, shows more clinical profusion levels on x-rays?
A. That is not quite as clear in the literature as the prior question. But there's some literature that shows increased profusion rate, although that varies. There's other literature that does not show that.
Q. 15. Doctor, are you familiar with Dr. Selikoff's work?
A. It depends on which part. It's extensive work.
Q. You met Dr. Selikoff?
A. I have, yes.
Q. You testified to that at your deposition. In one of Dr. Selikoff's earlier studies, 1986, would you agree with me in his study, he studied a population of asbestos workers and one of the things they looked at, they found out they had a smoking history with a majority of the workers?
A. Yes.
Q. You would agree with that?

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page 5915

A. Yes.
Q. And they found that the prevalence of all radiographic abnormalities, pleural and pulmonary, increased with duration from onset of asbestos exposure.
That would be our set of exposure here. A positive smoking history was associated with a significantly higher prevalence of small irregular opacities indicating interstitial pulmonary fibrosis.
A. It was associated with the higher prevalence of small irregular opacities. What the cause of that is though is really not completely determined.
Q. The mechanism?
A. Right, the mechanism. But certainly there is an increase of that.
Q. People smoking and exposed to asbestos had more abnormalities on chest X-rays?
A. Yes, especially at the lower level.
Q. And in 1991, the next one, please. Again they were looking at the effects of onset of exposure and smoking in asbestos workers. Blow up the chart, please.
Again, they saw the contribution of cigarette smoking to prevalence and severity of the interstitial fibrosis is an additional reason for smoking cessation among asbestos exposed. They go to a table 5 on that.
Would you agree with me that the cigarettes are

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actually contributing to the interstitial fibrosis?
A. Well, the cigarette smoking is contributing to increased x-ray readings, is really what was concluded from those studies.
Q. The cigarette smokers were found to have more interstitial pulmonary fibrosis, correct?
A. They were found to have x-rays read more frequently. However, it wasn't looked at in terms of a clinical disease process or other findings. That study was just looking at the x-rays.
Q. Will you agree with me, Doctor, that there are many studies that talk about the clearance mechanism being affected by smoking?
A. There are some animal studies as to that, yes.
Q. And Selikoff continues again, talking about the higher

rates of the abnormalities, and talking about the several recent findings, such an effect of smoking may be due to interference with pulmonary clearance mechanism and higher retention of asbestos fibers in the lung. Several recent experimental studies have converged in demonstrating that cigarette smoke inhibits asbestos clearance.
A. That's one of the theories that is given for increased chest x-rays being read with profusion scores.
Q. And a normal lung would have defense mechanisms to clear some of the asbestos fibers out?

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A. A lung would have those kind of defense mechanisms.
Q. And a damaged lung could inhibit the clearance mechanisms for asbestos fibers?
A. That's theoretical.
Q. And we established that asbestosis is a dose response disease, so the more asbestos fibers that are kept in your lungs the more apt you are to get disease?
A. That would be the theory.
THE COURT: Would your bring in to a close. There has to be a little time for the redirect.
Q. Have you seen internal documents from the industry showing their knowledge of the defense mechanisms being attacked by --
THE COURT: Don't answer.
MR. SCHROEDER: Objection.
Q. Dr. I want to finish up with, are you familiar with former Surgeon General, Dr. Richmond?
A. I know of him.
Q. Have you seen any of his statements to the public that cigarette smoking significantly increases the lung cancer risk of asbestos exposure and aggravates asbestosis?
A. I may have seen some of his statements awhile ago.
Q. But you disagree with former Surgeon General Richmond?
A. Well, I'm not sure that that quote is completely in context. I think it more means that cigarette smoking -- the

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lung cancer part of it we're not going to discuss, but it is more in line with two disease processes compromising the lungs, thereby aggravating the asbestosis.
Q. And Dr. --
THE COURT: That's enough. Thank you. Any redirect?
MR. SCHROEDER: Very brief, your Honor.
THE COURT: Yes.
REDIRECT EXAMINATION
BY MR. SCHROEDER:
Q. Dr. Mendelsohn, let me ask you about the Surgeon General's report real quick since Dr. Burns has testified to this jury that he wrote this section of the report that deals with asbestos.
THE COURT: You have on the board now what?
MR. SCHROEDER: Page 259 of the 1985 Surgeon General's report, your Honor.
Q. Do you see there, Doctor, it the questions raised by the combination of cigarette smoking and asbestos exposure do not include whether cigarette smoking is an independent competing cause of the extensive fibrotic process found in many workers following prolonged heavy exposure to asbestos.
Cigarette smoking has not been shown to independently cause this kind of reaction in the lung?

25 A. Yes.
page 5918
page 5919
1 Q. Do you agree with that?
2 A. Yes, I do.
3 Q. Further, on page 239, Dr. Burns writes. Asbestos and
4 cigarette smoke produce different appearance of injury in the
5 lung.
6 Do you agree with that?
7 A. Yes.
8 Q. And can you tell us, as a clinician with the appropriate
9 pulmonary function tests, determine those different patterns
10 in the lung?
11 A. For the most part, yes.
12 Q. Did the Trust follow those requirements, based on your
13 review of the claims files?
14 A. No.
15 Q. And, finally, here it says the demonstration -- on page
16 264, the demonstration of an increased prevalence of
17 roentgenographic changes interpreted as fibrosis in cigarette
18 smokers does not establish that the changes are produced by
19 smoking.
20 As has been discussed earlier, cigarette smokers may
21 have had a different cumulative asbestos exposure than
22 nonsmokers in some of the populations studied.
23 Do you agree with that?
24 A. Yes.
25 Q. Finally, Gregg Smith testified in this case: Has there
page 5919
page 5920
1 ever been a definitive study, to your knowledge, that smoking
2 increases the prevalence of asbestosis? Not that I've ever
3 seen. Page 22 of his deposition.
4 To your knowledge, is there a definitive study that
5 smoking increases the prevalence of asbestosis?
6 A. No.
7 Q. Finally, I'm going to show you a request for admission we
8 sent to the Trust in this case -- sorry, interrogatory number
9 14.
10 With regard to the contention, contained in paragraph
11 39 of your complaint, that the effect of cigarette smoking is
12 so overwhelming that in asbestos workers who smoked any
13 contribution of asbestos dust exposure to obstructive changes
14 in the lung functions are negligible. Please state the
15 factual basis.
16 Answer is. Additionally, plaintiffs state that the
17 Trust has known from its inception that smoking has a strong
18 role in causing obstructive changes in lung function.
19 Plaintiffs also state that they based the allegation contained
20 in paragraph 39 of the complaint that "the effect of cigarette
21 smoking is so overwhelming that, in asbestos workers who
22 smoked, any contribution of asbestos dust exposure to
23 obstructive changes in the lungs' functions are negligible,
24 and they pass on that to a passage in a book by Rogley.
25 Do you agree with that statement?
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page 5921
1 A. Yes, I do.
2 Q. Dr. Mendelsohn, if you apply the appropriate clinical
3 tests to determine lung function, can you determine those
4 kinds of obstructive changes and differentiate them from any
5 restrictive changes that may have been caused by asbestos?
6 A. Yes, for the most part you can.

Q. And was there any question asked to you on direct by Miss Kearse that changes at all your view of how many of the claims files passed clinical standards for the disease of asbestosis?
A. No.
MR. SCHROEDER: Thank you.
THE COURT: All right. Thank you very much.
Don't leave for a moment.
MS. KEARSE: Thank you, Doctor .
THE COURT: Yes. Thank you from all of us. Ten o'clock Tuesday, please. Don't discuss the case.
(Jury leaves the courtroom.)
THE COURT: Motions?
MR. BERNICK: I have several items, your Honor.
THE COURT: All right. I don't want to keep the doctor long. May I see that file, because I'm curious?
MR. BERNICK: Your Honor, I have several things. I don't mean to keep the doctor on the stand.
THE COURT: I want her.
MR. BERNICK: Sorry.

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MR. BERNICK: I'm out of order here. I apologize.
MS. KEARSE: This is another --
THE COURT: The file, please. I'm just curious about how the Trust operates, since I have had these cases.
This was which file, the -- was this the Collins file?
MS. KEARSE: Yes.
THE COURT: Collins, the 193?
MS. KEARSE: Yes.
THE COURT: So based on this you would not have found pleural disease or asbestosis?
THE WITNESS: I wouldn't have made a diagnosis of asbestosis just based on a chest x-ray. We didn't have any clinical information about what else may have caused it. There really wasn't very much exposure.
THE COURT: What about the pleural disease?
THE WITNESS: A pleural plaque is a more consistent marker so therefore the pleural plaque part of it I wouldn't really have an issue of it.
I wouldn't call it disease. A pleural plaque may or may not result in, you know, any kind of symptom in the individual, but I wouldn't have as much difficulty with that part of it.
THE COURT: So I take it, though, that under two on page 6, the worker was directly in contact with asbestos, and

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page 5923

if it was a very substantial amount of asbestos, your view might have changed?
THE WITNESS: If I had some more clinical information that it was significant, yes, then I would have had a different view.
THE COURT: So far as page 6, it's the problem of just checking without any exposition that you found troublesome?
THE WITNESS: Exactly. I think the clinical history could have really clarified it here. I'm not saying that the person didn't have asbestosis --
THE COURT: I understand the problem. So I take it, if you were handling a case like this and they asked your opinion, without seeing the patient, you would have sent it back and said you want further information on that point?

THE WITNESS: Yes.
THE COURT: Anything else you would have asked for?
THE WITNESS: I would have liked to have had the clinical information, not only the history but if the person was symptomatic. It would have been helpful.
It's not as crucial, given the level of the chest x-ray being higher than most, but I would have requested that clinical information.
THE COURT: And the Roentgenographic interpretation doesn't cut it?

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THE WITNESS: Just by itself, I didn't think it was enough.
THE COURT: All right. Thank you very much. It was very interesting. I don't see many of these files. Thank you.
(Witness excused.)
THE COURT: I hope everything goes well. Next, please.
MR. WAGNER: Your Honor, can I just hand up a list of documents that we were going to move admission into evidence? You will see a red box and some scratched out. Those are the ones I'm still working through with the plaintiff, so I will submit a separate list of those.
Everything on that list we are moving for admission into evidence. There is no objection.
THE COURT: All right. The last number was 79. This would be Court Exhibit 80.
MR. WAGNER: I will mark all of our copies accordingly.
THE COURT: Is this being accepted now?
MR. WAGNER: All of those are without objection. I will make a separate list, the ones that I have drawn a line through I will make a separate list of those because I'm still discussing it.
THE COURT: It's not necessary. The court reporter

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can list them. He will list everything on Court Exhibit 80 at this point in the record as admitted.
Court's Exhibit 80:
WS 000449.
SA 300198.
WS 003861.
SA 400192.
WS 002677.
ARF 000939.
ARF 001952.
WS 003967.
DEM 011033.
ARF 001540.
GJ 000004.
GI 000029.
GN 100659.
WS 002379.
GI 100012.
TG 000237.
GI 300139.
GI 300141.
GK 1000939.
GK 300212.
ARF 001485.

GJ 000113.
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GI 300109.
WS 003292.
GK 000018.
WS 000370.
GK 300319.
GL 300206.
WS 003792.
WS 003788.
WS 002996.
GK 300415.
GJ 000113.
WS 001490.
PX 350734.
THE COURT: Next.
MS. TEDDER: Your Honor, I'd like to hand the court back three exhibits which we have previously handed to the court.
Court Exhibit No. 64, which is the Kotin exhibits, which I think plaintiffs have no objection to. Court Exhibit 69 and 70.
Plaintiffs have seen both Court Exhibit 69 and 70, and there are three documents that I have -- one on the back of the last page of Court Exhibit 69, two on the last page of Court Exhibit 70, we are still discussing with the plaintiffs.
page 5926
page 5927
Other than that, they have no objections to any of the other documents.
THE COURT: I'm going to strike it from the list and you'll have to offer it separately.
MS. TEDDER: The three that are at issue?
THE COURT: Those three.
MS. TEDDER: Certainly.
THE COURT: Court Exhibit 64, Court Exhibit 69, Court Exhibit 70, I am handing to the reporter for adding to the record at this point all having been admitted.
Court Exhibit 64:
WZ-001401.
WZ-001387.
G B-300042.
SA-300718.
G B 300043.
SA-300620.
SA-300637.
SA 300638.
SA-300639.
SA-300640.
SA-300641.
SA-300642.
SA-600835.
SA-600836.
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SA-600149.
Court Exhibit 69:
SA-000099.
SA-000434.
SA-000071.
SA-000181.

 7 SA-000225.
 8 SA-000014.
 9 SA-000229.
10 SA-000292.
11 SA-000169.
12 SA-000091.
13 SA-000228.
14 SA-000318.
15 SA-000168.
16 SA-000233.
17 SA-000316.
18 SA-000227.
19 SA-000314.
20 SA-000235.
21 SA-000223.
22 SA-000226.
23 SA-000025.
24 SA-000465.
25 SA-000029.
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page 5929
 1 SA-000027.
 2 SA-000290.
 3 SA-000547.
 4 ARF-0001281.
 5 SA-000026.
 6 SA-0001923.
 7 SA-000231.
 8 SA-00214.
 9 SA-000187.
10 SA-000033.
11 SA-000002.
12 SA-000073.
13 SA-000435.
14 SA-000095.
15 SA-000121.
16 SA-00093.
17 SA-000118.
18 SA-000094.
19 SA-000102.
20 SA-000116.
21 SA-000023.
22 SA-000180:
23 SA-000126.
24 SA-000184.
25 SA-000114.
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page 5930
 1 SA-000092.
 2 SA-000124.
 3 SA-000111.
 4 SA-000112.
 5 SA-000096.
 6 SA-000090.
 7 SA-000108.
 8 SA-000123.
 9 SA-000433.
10 SA-000087.
11 SA-000107.
12 SA-000088.
13 SA-000105.
14 SA-000098.
15 SA-000100.

16 SA-000106.
17 SA-000103.
18 SA-000440.
19 SA-000470:
20 SA-000110.
21 SA-000097.
22 SA-000546.
23 SA-000178.
24 SA-000544.
25 SA-000172.
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page 5931
1 SA-000174.
2 SA-000232.
3 SA-000234.
4 SA-000317.
5 SA-000015.
6 SA-000313.
7 SA-000224.
8 SA-000230.
9 SA-000028.
10 SA-000195.
11 SA-000194.
12 SA-000023.
13 SA-000005.
14 SA-000122.
15 SA-000543.
16 SA-000315.
17 SA-000545.
18 Court Exhibit 70:
19 ARF-001951.
20 ARF-001953.
21 GD-000005.
22 GD 300040.
23 GK-300167.
24 GK 300198.
25 GK-300316.
page 5931
page 5932
1 GK 300330.
2 GM-300043.
3 SA-300185.
4 SA-300484.
5 SA-300495.
6 SA-300510.
7 SA-300735.
8 SA-300736.
9 SA-300737.
10 SA-300738.
11 SA-300739.
12 SA-300740.
13 SA-300741.
14 SA-300742.
15 SA 300743.
16 SA-300744.
17 SA-300745.01.
18 SA-300745.08.
19 SA 300752.
20 SA-400024.
21 SA-400186.
22 SA-400278.
23 SA-400514.
24 SA-400524.

25 TG-000002.
page 5932
page 5933
1 TG-000237.
2 6412.
3 GR-001212.
4 SA-100003.
5 SA-100018.
6 SA-100019.
7 SA-100020.
8 SA-200326.
9 SA-200329.
10 SA-300259.
11 SA-300261.
12 SA-3002636789.
13 SA-3002716789.
14 SA-3002736789.
15 SA-300275.
16 SA-300276.
17 SA-300277.
18 SA-300281.
19 SA-300294.
20 SA-3003427.
21 SA-300331.
22 SA-300360.
23 SA-300364.
24 SA-300377.
25 SA-300459.
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page 5934
1 SA-300469.
2 SA-300471.
3 SA-300476.
4 SA-300477.
5 SA-300593.
6 SA 300596.
7 SA-300599.
8 SA-300600.
9 SA-300600.
10 SA-300604.
11 SA-300687.
12 SA-305689.
13 SA-300696.
14 SA-300698.
15 SA-300699.
16 SA-300721.
17 SA-300722.
18 SA-300323.
19 SA-300730.
20 SA-300732.
21 SA-300733.
22 SA-300734.
23 SA-300746.
24 SA-300747.
25 SA-300748.
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1 SA-300749.
2 SA-300750.
3 SA-300751.
4 SA-300753.
5 SA-300754.
6 SA-300757.

SA-400313.
SA-400314.
SA-400351.
SA-400354.
SA-400356.
SA-400359.
SA-400361.
SA-400363.
SA-400364.
SA-400371.
SA-400372.
SA-400390.
SA-400396.
SA-400415.
SA-400437.
SA-400534.
SA-400535.
SA-400536.
Plaintiff's Exhibit 35412.
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Plaintiff's Exhibit 42402.
Plaintiff's Exhibit 42413.
Plaintiff's Exhibit 43031.
Plaintiff's Exhibit 43122.
Plaintiff's Exhibit 43136.
Plaintiff's Exhibit 43609.
Plaintiff's Exhibit 43904.
Plaintiff's Exhibit 43989.
Plaintiff's Exhibit 80029.
Plaintiff's Exhibit 80042.
Plaintiff's Exhibit 80117.
Plaintiff's Exhibit 80118.
Plaintiff's Exhibit 80118.
Plaintiff's Exhibit 80153.
Plaintiff's Exhibit 80229.
Plaintiff's Exhibit 80269.
Plaintiff's Exhibit 80316.
Plaintiff's Exhibit 80728.
Plaintiff's Exhibit 81038.
Defendant's Exhibit TG 000353.
Defendant's Exhibit SA 300198.
Defendant's Exhibit SA 400192.
Defendant's Exhibit SA-400437.
Defendant's Exhibit SA-400437.
Defendant's Exhibit SA-300042.
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page 5937
MR. KRAUS: Your Honor, I have just one document to offer in evidence as to which the plaintiffs have told me there is no objection, and that is Defendant's Exhibit as 000546. This was used during Mr. Townsends' examination.
THE COURT: Admitted.
(So marked.)
MR. BERNICK: Your Honor, in order to give you some relief from the mundane process of documents, I have some other issues that I'd like to raise with the court.
THE COURT: Are there any other document issues?
MR. BERNICK: I have some as well, but --
MR. WESTBROOK: We have one a little behind.
THE COURT: Let's take care of all the documents.
MR. WESTBROOK: We have a list of Martin cross-examination documents, that was Court Exhibit 72, that

you marked the other day that I will hand back to the court.
THE COURT: Court's Exhibit what?
MR. WESTBROOK: 72. I will hand to the court.
THE COURT: Is that agreed to now?
MR. WESTBROOK: No, your Honor. Let me tell you where we are. There is one exhibit for the record, 50093, which was some polling data. Defendants ask that we add some pages, they have given us the pages and we have agreed to add those pages.
THE COURT: Admitted with that change.

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MR. WESTBROOK: There are four ads which are 76050, .0135, 135 .911, .913 --
THE COURT: Wait a minute.
MR. WESTBROOK: .92 --
THE COURT: Excuse me.
MR. WESTBROOK: 0135 --
THE COURT: May I see 76050, please. 135. I don't see the others.
MR. WESTBROOK: You will see .911. Under that is .913. Two under that is .924. The defendants want to preserve their objection. Those we are pre-53 ads that I used with Professor Martin who went back to 1600.
THE COURT: They are all going in.
MR. WESTBROOK: The only other item we have, your Honor, is I used with Professor Martin a 1977 Federal Trade Commission review of polls and I read to him certain pages from the overview.
We move to put this in as a 1977 government report. The defendant says it's a learned treatise and only want those pages in --
THE COURT: That's all I want. It's much too complicated. What number is this?
MR. WESTBROOK: 50379.01.
THE COURT: Yes. Only those pages are admitted, and the title page.

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MR. WESTBROOK: I read from page I and II.
THE COURT: All right. With those rulings, Court Exhibit 72 is admitted. I'm handing it to the reporter to please include it in the transcript at this point as admitted.
Court Exhibit 72:
255.
318.
742.
2019 (50093).
3084.
5026.
5143.
5414.
5435.
7016.
7692.
7738.
7749.
8023.
8717.
9445.
10021.
13762.

14664.
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18147.
20022.
28962.
32088.
37087.
43305.02.
44354.
44365.
44530.
44531.
44532.
50093.
50379.01.
50507.
50724 (50731).
76050.0135.
76050.0145.
76050.0468.
76050.911.
76050.913.
76050.921.
76050.922.
76050.924.
76196.003.
76341.002.
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76341.015.
76341.015 (a).
80451.
80596.
80691.
80724.
Martin Movie Clips 1, 2, 3, 4, 5 and 6.
Martin TV Clips 3, 6, 7 and 9.
Martin videos 1, 2, 4, 5 and 8.
Martin Demonstrative 3.
P Martin 1.
P Martin 1 B (50734 B).
P Martin 2 (80627)
MR. WESTBROOK: Your Honor, I think Mr. Bernick wants to reserve the right to move to strike on the list should he find something that he wants to argue about.
THE COURT: I will take that at any time, a motion to strike.
MR. KRAUS: One last thing with respect to the list. Several of those documents were the R.J. Reynolds letters to schools and, obviously, I had objected to those previously, your Honor, and I want the record to reflect that we continue to object to those.
THE COURT: Overruled.
MR. MARK: Your Honor, plaintiffs mentioned 911,
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which is a Chesterfield add from Liggett. I think plaintiff is in agreement that the language noted on black on the left margin of that exhibit has nothing to do with that ad and should be redacted.
MR. WESTBROOK: We agree. I don't think it's on other copy. We agree to that.

THE COURT: Redact it. Admitted. Any other document points?
MR. BERNICK: I have a document issue. Court's Exhibit 75 is materials used with Wecker and I don't believe there's any objection to those.
THE COURT: Court's Exhibit 75 is admitted.
MR. STENGEL: No objection.
THE COURT: I'm handing it to the reporter. Would you please enter it into the record at this point.
Court Exhibit 75:
GZ-201203 (aka GN-100316).
GZ-201204 (aka GN-100315).
GZ-201264.
WZ-000590.
Wecker 001 (aka DEM-012072).
Wecker 002 (aka DEM-012073).
Wecker 003 (aka DEM-012104).
Wecker 004 (aka DEM-0121103).
Wecker 005 (aka DEM-012074).
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Wecker 006 (aka DEM-012076).
Wecker 007 (aka DEM-012077).
Wecker 008 (aka DEM-012078).
Wecker 009 (aka DEM-012079).
Wecker 010 (aka DEM-012079 A).
Wecker 011 (aka DEM-012080).
Wecker 012 (aka DEM-012081).
Wecker 013 (aka DEM-012082).
Wecker 014 (aka DEM-012085).
Wecker 015 (aka DEM-012086).
Wecker 016 (aka DEM-012088).
Wecker 017 (aka DEM-012089).
Wecker 018 (aka DEM-012090).
Wecker 018 A (aka DEM-0121105).
Wecker 019 (aka DEM 012091)
Wecker 020 (aka DEM 012075).
Wecker 022 (aka DEM-0120092).
Wecker 023 (aka DEM-0120095).
Wecker 024 (aka DEM-012094).
Wecker 024 A (aka DEM-012093).
Wecker 026 (aka DEM-012097).
Wecker 027 (aka DEM-012098).
Wecker 025 (aka DEM-012096).
Wecker 025 A (aka DEM-121106).
Wecker 028 (aka DEM-0120099).
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page 5944
Wecker 029.
MR. BERNICK: Here's another list of materials that have been or will be used and we have not had the opportunity -- I know plaintiffs' counsel still hasn't received it. We would like to have it entered as a Court Exhibit.
THE COURT: Court's Exhibit 81. I am returning it to the defendant for checking with the plaintiff.
MR. BERNICK: Thank you.
THE COURT: Anything further?
MR. BERNICK: Yes. We have -- I will give this to you in a moment, we have a proposed instruction regarding --
THE COURT: That ends our document problem?
MR. BERNICK: I don't have any other document issues. I should say, we will reserve -- this is more a

substantive point -- DEM 12150, a demonstrative that we would used to place into context with Dr. Dunbar, the claim of the plaintiffs in this case, and we reserve on our right to supplement the record through Dr. Dunbar to have him respond to the plaintiffs' claim in the case, which we sill do not have. I want to make that clear on the record.

THE COURT: You can put it in next week if there's a basis.

MR. BERNICK: We would tender up to the court a proposed instruction regarding the Surgeon General 2000

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report.

THE COURT: Marked Court's Exhibit 82.

MR. WESTBROOK: We have just been handed this, your Honor.

THE COURT: Okay. Go over it over the weekend and I'll hear you on it on Monday. Yes, on Monday.

MR. BERNICK: Your Honor, there are a few other matters. Number one, we still do not have at this late date the damage claim for the plaintiffs.

It's now becoming so extreme as to be bizarre. Mr. Austern was so calm and fluid this morning, explaining the matrix, I don't know what the problem is, why we don't have numbers, but we don't have the numbers.

Can we find out when we're going to get them?

THE COURT: Yes. Do you have any indication from the Trust?

MR. STENGEL: I have been in this room all day, so it's hard for me to say.

THE COURT: When you get a chance, get on the phone and -- we have to have those numbers.

MR. STENGEL: I will give Mr. Bernick a call this evening and make sure he knows.

THE COURT: If you can't give them to us, I'm not going to let you go forward with the 2001 and 2002.

MR. STENGEL: Understood, your Honor.

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MR. BERNICK: Second, we would, on the basis of the testimony that was offered this morning from Dr. Harris and the further comments -- any information to the court -- further comments by Dr. Wecker, we want to make sure that we preserve our record and renew our motion to strike any testimony from Dr. Harris on any matter, and in particular those matters that were provided to us within the last twenty-four hours.

(Continued next page)

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THE COURT: Decision reserved until I hear his testimony.
MR. BERNICK: Second to last, we have some -- we are trying to expedite the completion of the case and I have made some proposals to counsel regarding the submission of deposition testimony just into the record without taking up the jury's time to hear it and other matters. We are trying to move forward.
I think that you now have heard from our last live witness so it is just a matter at this point of some videotapes. We are even prepared to cut those down if we can develop some notion of what the plaintiffs' really anticipate the schedule is going to be with their matters.
THE COURT: You mean, the -- I assume that you were going to have Doctor Wecker, if he is available, listen in on the testimony.
MR. BERNICK: Yes.
THE COURT: You might use him. I will take him by telephone.
MR. BERNICK: Well, actually, what we would do if they are going to call Doctor Harris on Tuesday, we will want to put Doctor Wecker on the stand to respond to that.
THE COURT: Physically or by telephone?
MR. BERNICK: Absolutely, physically.
THE COURT: Okay. You may not get to summations
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until Wednesday.
MR. BERNICK: We are prepared to try to cut back on the depositions.
THE COURT: I am not in any rush. We have moved very quickly.
MR. BERNICK: If we in fact complete the proofs on Tuesday, what would be Your Honor's anticipation about closings?
THE COURT: We have that one juror who is off one day next week.
MR. BERNICK: Thursday.
Do we know what time of day he has the appointment?
THE COURT: I made inquiry of Ms. Lowe. Apparently, he is buying merchandise or something for the year and he has to go through a trade show from one floor after another. He indicated he probably needed a full day, but we will see if we can reduce that. I don't think we can have much hope of that.
MR. BERNICK: If that's so, if we were finishing the proofs on Tuesday, and we had a dark day on Thursday, when would be your inclination to have closings take place?
THE COURT: Well, Wednesday and Friday, I suppose. The alternative would be just close down for the rest of that week and start fresh on the following Monday.
MR. BERNICK: My --
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THE COURT: It would give us all breathing room on the charge and summations, on getting the evidence shaped up and everything else. In view --
MR. BERNICK: My sense is that juror number one, and maybe there are others, are somewhat anxious to get back to their ordinary lives.

THE COURT: That's the problem. But they really can't complain. They were promised a ten-week trial. That may happen of course, or more.

I will think about it. I always prefer to move ahead.

MR. BERNICK: Okay. The last -- the last point, and I am reluctant to raise it because it will sound out of place, but when Your Honor put the question to the last witness about the relevance of her testimony, when she said I think, in essence, that she didn't believe that there was sufficient information to reach a clinical diagnosis with respect to a claim.

THE COURT: Yes.

MR. BERNICK: It made it sound as if what the Court is saying is that it doesn't make a difference, it is not precisely relevant, whether there was a proper diagnosis or not, as long as it was reasonable for the Trust to pay.

THE COURT: Yes. All right.

You are right on that. I agree.

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Give me a request to charge and I will give it.

MR. BERNICK: I guess Monday at ten we are to be here to take up the charge?

THE COURT: Well, I was thinking of nine.

MR. BERNICK: I'm sorry?

THE COURT: I was thinking of 9:00 o'clock.

MR. BERNICK: I don't think we have anything else to do, Your Honor, other than to work on our closings. So we are more than happy to be here at 9:00 o'clock.

THE COURT: It may take more time. There may be document problems that come up because you are putting together your final lists and so on.

Is it reasonable? I don't want to press you.

MR. BERNICK: It's fine.

THE COURT: 9:00 o'clock. Then we can break early.

MR. SCHROEDER: In that regard, in order to be able Monday to do what we need to do with documents, we have been trying to get from the plaintiffs their videos that they have shown because they haven't been transcribed during the trial. We really need to have those this weekend to be prepared Monday to deal with those. Can we get those sometime this weekend?

MR. WESTBROOK: I just saw I think the last few video transcribed transcripts to be checked and then we are going to submit them to the other side to be sure the transcripts,

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everybody matches what was played. I think that's in process. People in our office --

MR. SCHROEDER: Can we get them before mid-day tomorrow? Is that a problem?

MR. WESTBROOK: Yes.

MR. SCHROEDER: Thank you.

MR. WESTBROOK: We will convey that. I don't think it should be a problem, Your Honor. If it is we will call. We will relay the message when we go back.

THE COURT: Anything further?

I was a little troubled. There are a number of troublesome problems with this charge, obviously. If you have any full submission on the issue of joint and several -- I take it, the defendants want me to set it up at least so the jury can decide whether there is joint liability or individual

liability. I would suppose Liggett would want that.
MR. FEIWUS: Yes, Your Honor.
THE COURT: I will have to have a charge. I am not sure that we have gone into it in sufficient detail.
MR. BERNICK: We will think about that.
THE COURT: There was something else I was troubled by.
We may move around parts. You'll also have to have your statements of factual theory for the front end.
MR. MANSFIELD: Your Honor has in mind two paragraphs

or so?
THE COURT: Yes, something like that.
MR. MANSFIELD: On Monday can we also take up the proposed verdict form as well?
THE COURT: Yes. I know the defendants want a much more comprehensive one.
All right. Thanks very much for all of your help. Enjoy your weekend.
(Recess taken until 9:00 o'clock, Monday, January 15, 2001.)

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25 SA-300637.
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1 SA 300638.
2 SA-300639.
3 SA-300640.
4 SA-300641.
5 SA-300642.
6 SA-600835.
7 SA-600836.
8 SA-600149.
9 Court Exhibit 69:
10 SA-000099.
11 SA-000434.
12 SA-000071.
13 SA-000181.
14 SA-000225.
15 SA-000014.
16 SA-000229.
17 SA-000292.
18 SA-000169.
19 SA-000091.
20 SA-000228.
21 SA-000318.
22 SA-000168.
23 SA-000233.
24 SA-000316.
25 SA-000227.
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1 SA-000314.
2 SA-000235.
3 SA-000223.
4 SA-000226.
5 SA-000025.
6 SA-000465.
7 SA-000029.
8 SA-000027.
9 SA-000290.
10 SA-000547.
11 ARF-0001281.
12 SA-000026.
13 SA-0001923.
14 SA-000231.
15 SA-00214.
16 SA-000187.
17 SA-000033.
18 SA-000002.
19 SA-000073.
20 SA-000435.
21 SA-000095.
22 SA-000121.
23 SA-00093.
24 SA-000118.
25 SA-000094.
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1 SA-000102.
2 SA-000116.
3 SA-000023.
4 SA-000180:
5 SA-000126.
6 SA-000184.

 7   SA-000114.
 8   SA-000092.
 9   SA-000124.
10   SA-000111.
11   SA-000112.
12   SA-000096.
13   SA-000090.
14   SA-000108.
15   SA-000123.
16   SA-000433.
17   SA-000087.
18   SA-000107.
19   SA-000088.
20   SA-000105.
21   SA-000098.
22   SA-000100.
23   SA-000106.
24   SA-000103.
25   SA-000440.
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 1   SA-000470:
 2   SA-000110.
 3   SA-000097.
 4   SA-000546.
 5   SA-000178.
 6   SA-000544.
 7   SA-000172.
 8   SA-000174.
 9   SA-000232.
10   SA-000234.
11   SA-000317.
12   SA-000015.
13   SA-000313.
14   SA-000224.
15   SA-000230.
16   SA-000028.
17   SA-000195.
18   SA-000194.
19   SA-000023.
20   SA-000005.
21   SA-000122.
22   SA-000543.
23   SA-000315.
24   SA-000545.
25   Court Exhibit 70:
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 1   ARF-001951.
 2   ARF-001953.
 3   GD-000005.
 4   GD 300040.
 5   GK-300167.
 6   GK 300198.
 7   GK-300316.
 8   GK 300330.
 9   GM-300043.
10   SA-300185.
11   SA-300484.
12   SA-300495.
13   SA-300510.
14   SA-300735.
15   SA-300736.

16 SA-300737.
17 SA-300738.
18 SA-300739.
19 SA-300740.
20 SA-300741.
21 SA-300742.
22 SA 300743.
23 SA-300744.
24 SA-300745.01.
25 SA-300745.08.
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1 SA 300752.
2 SA-400024.
3 SA-400186.
4 SA-400278.
5 SA-400514.
6 SA-400524.
7 TG-000002.
8 TG-000237.
9 6412.
10 GR-001212.
11 SA-100003.
12 SA-100018.
13 SA-100019.
14 SA-100020.
15 SA-200326.
16 SA-200329.
17 SA-300259.
18 SA-300261.
19 SA-3002636789.
20 SA-3002716789.
21 SA-3002736789.
22 SA-300275.
23 SA-300276.
24 SA-300277.
25 SA-300281.
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1 SA-300294.
2 SA-3003427.
3 SA-300331.
4 SA-300360.
5 SA-300364.
6 SA-300377.
7 SA-300459.
8 SA-300469.
9 SA-300471.
10 SA-300476.
11 SA-300477.
12 SA-300593.
13 SA 300596.
14 SA-300599.
15 SA-300600.
16 SA-300600.
17 SA-300604.
18 SA-300687.
19 SA-305689.
20 SA-300696.
21 SA-300698.
22 SA-300699.
23 SA-300721.
24 SA-300722.

25 SA-300323.
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1 SA-300730.
2 SA-300732.
3 SA-300733.
4 SA-300734.
5 SA-300746.
6 SA-300747.
7 SA-300748.
8 SA-300749.
9 SA-300750.
10 SA-300751.
11 SA-300753.
12 SA-300754.
13 SA-300757.
14 SA-400313.
15 SA-400314.
16 SA-400351.
17 SA-400354.
18 SA-400356.
19 SA-400359.
20 SA-400361.
21 SA-400363.
22 SA-400364.
23 SA-400371.
24 SA-400372.
25 SA-400390.
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1 SA-400396.
2 SA-400415.
3 SA-400437.
4 SA-400534.
5 SA-400535.
6 SA-400536.
7 Plaintiff's Exhibit 35412.
8 Plaintiff's Exhibit 42402.
9 Plaintiff's Exhibit 42413.
10 Plaintiff's Exhibit 43031.
11 Plaintiff's Exhibit 43122.
12 Plaintiff's Exhibit 43136.
13 Plaintiff's Exhibit 43609.
14 Plaintiff's Exhibit 43904.
15 Plaintiff's Exhibit 43989.
16 Plaintiff's Exhibit 80029.
17 Plaintiff's Exhibit 80042.
18 Plaintiff's Exhibit 80117.
19 Plaintiff's Exhibit 80118.
20 Plaintiff's Exhibit 80118.
21 Plaintiff's Exhibit 80153.
22 Plaintiff's Exhibit 80229.
23 Plaintiff's Exhibit 80269.
24 Plaintiff's Exhibit 80316.
25 Plaintiff's Exhibit 80728.
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1 Plaintiff's Exhibit 81038.
2 Defendant's Exhibit TG 000353.
3 Defendant's Exhibit SA 300198.
4 Defendant's Exhibit SA 400192.
5 Defendant's Exhibit SA-400437.
6 Defendant's Exhibit SA-400437.

Defendant's Exhibit SA-300042.